

THE MEDICAL AND SURGICAL REPORTER.

No 1942.

PHILADELPHIA, MAY 19, 1894.

VOL. LXX—No. 20

ORIGINAL ARTICLES.

THE MARRIAGE OF SYPHILITICS.

WILLIAM G. PORTER, M. D.,* PHILADELPHIA.

MR. PRESIDENT AND FELLOWS OF THE COLLEGE OF PHYSICIANS: Perhaps no more important or interesting question could have been submitted for our discussion to-night than that of the Marriage of Syphilitics, and I must confess that I approach its consideration with an amount of diffidence which I would not have supposed to be possible some years ago. It would be very easy to dispose of the whole question by giving to our patients who have been afflicted with syphilis and who are contemplating matrimony the celebrated advice of Mr. Punch to those about to be married, "*Don't!*"

But in regard to this question we have a solemn duty to perform; on our decision may depend the future happiness and health, not only of our patient, but that of an innocent and virtuous woman and of children yet unborn.

The subject is so large in all its bearings that it will be simply impossible for me to more than outline some of its more salient points to-night. In approaching the subject we must consider first *our patient*.

If we forbid him to marry, and he takes our advice, we condemn him to perpetual celibacy—we rob him of all the joys of matrimony, of possible paternity.

If we are right in our judgment we have nothing with which to reproach ourselves.

But if we have acted inadvisedly; if he is really incapable of transmitting the disease to others; if he is capable of procreating healthy children; if he has a long

life of health and usefulness before him; if, in other words he is cured—we have done him a lasting injury, we have blighted his life, we have robbed the State of a citizen who would in all probability have been more useful married than single.

On the other hand, if we advise our patient, who is or has been syphilitic, that he can safely marry, and he follows our advice and infects his wife or procreates syphilitic children, we have not only injured him, but inflicted irreparable injury on an innocent wife and helpless children.

Now, gentlemen, are there any rules which may guide us in the determination of this most important question? Of course, in an assemblage of physicians like this it would be entirely out of place for me to address you as I would a class of students. You are all more or less familiar with the disease. Many of you are experts in its detection and treatment, both as specialists and as general practitioners. In the limited time at our disposal it would be impossible to offer the proofs of all the statements I shall make; I must, therefore, endeavor to limit myself to propositions which, I think, we can all endorse, and see if we can reasonably make any deductions from them.

In the first place, then, I would say that syphilis may be classified for our purpose into three varieties, viz., the benign, the moderate, the malignant.

I suppose that it has occurred to all of us *occasionally* to have seen cases of primary syphilis which have been followed by an exceedingly moderate amount of secondary symptoms, and then, almost without treatment, by perfect recovery and the

*Senior Surgeon to the Philadelphia Hospital; Surgeon to the Presbyterian Hospital.

absence of further manifestations; to these I would apply the name of benignant.

By moderate syphilis I mean those ordinary cases in which the disease runs through its various stages without severe symptoms—perfectly responsive to treatment, generally controlled by it, but which it may take many months or perhaps some years to cure.

By malignant syphilis I mean those cases which are very severe from the start, in which the earliest secondary symptom may be a rupia with a profound cachexia, or immediately on the disappearance of the chancre, or even sometimes before it has disappeared, the nervous system of the patient may be profoundly affected.

Recognizing these three varieties, my next proposition is that all three forms are generally curable: the first exhausting itself, the latter two requiring the treatment of the *skillful* physician to overcome them. Gentlemen, I say *skillful* physician, for there is no disease which responds more rapidly to proper treatment or shows worse results when improperly treated than syphilis.

We know that syphilis is curable from the fact that many patients remain indefinitely without a recurrence of symptoms, and more than all that, they not infrequently contract it a second time. But up to the present time no means has been discovered by which we can say absolutely to any individual patient, "You are cured; you will never have a return of this disease unless you contract it again." Because of this many writers on syphilis claim that as we can never say absolutely that a patient is cured, we have no moral right to advise him to take the chances of matrimony; that we can never tell, even after the lapse of years, when a relapse may occur, and the patient, who has supposed himself to be cured, may transmit to his posterity this terrible disease. Now, it seems to me if there is one thing established in medicine, it is the power of medical treatment over the manifestations of syphilis. Who among you has not seen symptoms disappear under treatment almost as if by magic, cases apparently the most hopeless restored to health, and yet it happens to all of us occasionally to see cases which, in spite of systematic and long-continued treatment, persistently relapse. They are not really ill; they go about attending to business and the affairs of life as usual; and yet we

know and they know that they are not well; the slightest indiscretion is sure to produce a temporary relapse, and so it goes on for years and years. I think that all of us who have been in practice for twenty-five years or more must recognize the fact that we do not see nearly as many severe cases of syphilis as we formerly did, and yet if we consider the numberless pathological conditions which it most assuredly causes, we must admit that it is still a most serious affection, and one which results much more frequently in death than is generally supposed.

Now, under what, if any, circumstances, are we justified in informing a patient who has suffered from this disease that it will be safe for him to marry?

In the first place, marriage should be absolutely forbidden to any patient who presents at the time he consults us any of the symptoms of syphilis—primary, secondary, or tertiary. Let me quote here from the master of this subject—Fournier:

"What then is marriage in its completeness, gentlemen? Marriage is not only an affair of sentiment, of passion, of convenience, and of interest; to consider it from a standpoint more practical and at the same time more elevated. Marriage is an association freely entered into, where each contracting party is pledged to bring in good faith a share of health and physical vigor, with the view of co-operating, on the one hand, for the material prosperity of the family, and, on the other hand, for the raising of children, the supreme and sacred end of every union.

"Now what, in this case, I ask you, will be the share contributed to the partnership by a husband syphilitic, and not cured of his syphilis? His share will be that of a health compromised, hypothesized, burdened with a debt hereafter due the pox, that pitiless creditor."

"On account of the pox it may happen that this man may experience one day or another such and such serious affections which will ruin his health, such and such an infirmity which will render him incapable of work, incapable of earning his daily bread; and then what will become of the family, of which this man is the recognized support? what will become of his wife? what will become of his children?"

"On account of the pox also this man may die. What may happen, he being

dead, to his wife and to these children?

"Is it admissible, then, that a man should think of creating for himself a family when he is liable to fail this family? Is it admissible? Is it right? Is it mortal that a man should dream of having a wife and children when he offers the possible prospect of widowhood to this wife, of orphanage to these children, of poverty to this family? No, a hundred times No!

"Also, and I do not hesitate to say it, the man who is syphilitic, and not cured of his syphilis, fears not nevertheless to append his signature to the marriage contract, commits at this moment a base act, an act immoral and corrupt, an act which good people will be unanimous in condemning."

In the second place, marriage should be absolutely forbidden to all syphilitic patients who have not been subjected to a most thorough, complete, and prolonged treatment.

And finally, in the third place, before sanctioning the marriage of a syphilitic, the requirement of a sufficient treatment having been fulfilled, the physician should be satisfied that he is in perfect health, and that he has had no symptoms, even suspicions, of syphilis for a period of at least two years.

Under these circumstances, and with these limitations, I have no hesitation in telling patients that I think they are reasonably safe in marrying, and I have never yet had reason to regret the advice which I have given.

HYDROPHOBIA.

HIRAM CORSON, M. D., PLYMOUTH MEETING, PA.

[CONTINUED FROM PAGE 672.]

CASES.

CASE REPORTED BY DR. JOHN W. GREEN, OF NEW YORK.—When Dr. Green had heard his statement and that he had been bitten by a dog, he sent for his family physician. They met late at night and advised a course of treatment; but he would do nothing, and said, "There is no hope for me. I must die." The nervous disturbance increased; he could not sleep; was restless; asked them to stop him, so that he could not hurt anyone. At eleven o'clock next day he was attacked with a convulsion; four or five strong men seized him, threw him on the bed, face down, and from fear of injury kept him there till the spasmodic action ceased. When they loosed their hold he was dead.

Yet this case of mental terror was reported to the Committee of the American Medical Association as a case of hydrophobia.

CASE 24 OF THE REPORT.—Mr. Hopkins was punishing his own dog that showed no signs of ill health or madness, and was bitten by him. Two days later he untied the dog and he went away. This frightened Mr. Hopkins and he began to read about hydrophobia and talk

about it. His mind continued to be greatly occupied, but he was not attacked for nearly three months. He was then ordered Dover's Powders, 10 grains every hour; at 10 P. M. tincture of aconite was added. He died sixty-one hours from the attack.

How evident, that it was the result of brooding so long over the fear of hydrophobia.

DR. WINTHROP SARGENT'S CASE.—I have had one case, in 1849, at Manayunk. Drs. Thomas Betten, Conroy and two others saw it. Dr. Betten said he had some experience with the disease and pronounced it a perfectly sure case. The patient had been bitten some weeks prior by a slut that had a litter of pups, with which he was meddling, which aroused her anger and caused her to bite him. After the biting she was chased away with intent to kill her, but they did not succeed, and it was not until some time after the patient died that the slut returned perfectly well and was permitted to live.

How convincing is this case that mental terror led to feelings and acts which this man had heard were attendant on hydrophobia, and the nervous system gave way to his fears.

DR. W. L. ATLEE'S CASE, No. 11.—Mrs. Kelly, bitten November 3d, 1838. Dr. Penypacker saw her on the 5th. Ordered wound washed with salt and water, and a salt poultice applied. Was advised to try Stoy's cure. Went through a full course after which she was quite well, until about three weeks before Dr. Atlee was called (February 9th, 1839), from which time, until then, she had not been very well. It was a pain in the arm extending to the shoulder, for the last three days. She had blistered the arm after first using a liniment on it. But she had not got relief. Dr. Atlee had been sent for.

It was evident to Dr. Atlee that both herself and her husband feared the dog bite was the cause. Indeed, the husband so declared for himself. It was then 9:30 A. M. From this time the doctor's conduct must have been to her strong confirmation of her worst fears. She had sent for him because of rheumatism, as she averred, and he writes: "I found the symptoms as above described, with the pain more acute in the joints than elsewhere, taking in the character of the local symptoms of acute rheumatism. Her countenance was anxious and her manner a little hurried." I ought to say, that on this visit he did not know that the dog had bitten her. She only complained of rheumatism, and that he prescribed for. On leaving her he told her, "To send word for him in the morning, if she was not better, or sooner, if she became worse." The next morning he saw her at 9:30 o'clock. She had spent a bad night. Soon after going to bed felt as if suffocating, with pain at precordia, etc., and after that could not sleep. Every few minutes she would start up in great distress and sense of smothering. [This increase of distress was evidently due to the doctor's expressed wish to be sent for if she got worse.] It was at this visit, Saturday morning, that Dr. Atlee learned all about the dog-bite and the Stoy remedy, so Dr. Atlee adds: "After giving me this history of herself, she said 'she did not believe the disease was from the dog bite,' but her manner disclosed that she secretly believed *that* to be the cause." Dr. Atlee had gone then at 9:30 A. M. and the long story of her case had been told him by her, her husband, too, being present. So it was doubtless 10 o'clock before he left.

At one o'clock he visited her again. He writes: "She received me tranquilly and expressed herself glad to see me. Her husband said 'he believed her illness came from the bite of the dog.' She said, 'No; it's rheumatism. I will soon be well of the spasms.'" At 3:30 P. M. he visited her, having his brother, Dr. John, with him. "The visit of my brother produced no unusual agitation. She seemed glad to see us and got up and offered us chairs requesting us to be seated. Called again at 8 P. M.; she was no better. On next day, the 11th, visits at 8 and 11 A. M. and at 3, 6 and 8 P. M., five visits in a day. During that day she was much engaged in prayer. Had Dr. Atlee to read parts of scripture to her, first the 52d chapter of Isaiah. Then she said, 'I am afraid of tiring you, but I would like to hear more.' Then I read eight or nine succeeding chapters, at the end of each chapter asking her if I should read more. She replied, 'You are too kind; but if you are not tired I should like you to read of the sufferings and death of our Saviour.' I then turned to Matthew and read for her. During all this time she remained perfectly tranquil and composed, although her spasms had been so violent before." Before I left she desired to know my opinion of her case. By suggestion of Dr. Atlee a clergyman was called; she talked freely with him. At this time there were four doctors. "The clergyman was engaged with her, in conversation and prayer, about half an hour. During the whole of this period she was remarkably calm and free from spasms, although her paroxysms before and immediately after were frequent and of the most violent character."—p. 277. "It would appear from this," says Dr. Atlee, "as if the exercise of the mind had some mysterious connection with the production of spasms. For as the paroxysms were entirely suspended while the mind was engaged in this all-absorbing question, and as they reoccurred as soon as the mind was not thus exercised, it would indicate almost as close a relation as cause and effect."

[The members of the profession will observe the correspondence between this circumstance of this case, and a distinguishing feature of chorea, viz: the act of volition being necessary to the convulsive movement. For *volition* substitute nervous system.—H. C.]

The case went on. Spasms, no food, no drink, much medicine, quiet rational spells. At no time was it needful to tie her or restrain her. No disposition to bite, no barking like a dog, though she was somewhat hoarse. She sat in a chair during the whole course of this disease fearing suffocation if she should lie on the bed. She died at 11.30 A. M. on the 13th. Four days after the attack began, about as it appears from the history of numerous cases, as life can be maintained (I suppose) under such a fierce strain of the nervous system. Spasms, no food, no water, no rest in bed and much medicine.

Effect of a Dog's Bite.

**AFTER SUFFERING INTENSELY FOR DAYS,
A MAN DIES IN TERRIBLE AGONY.**

Lynn, Mass., June 8.—John Anderson, a Swede, three weeks ago was bitten on the hip by a dog. The wound was not cauterized and Anderson was taken ill on Monday, and at once had a decided antipathy to water.

Tuesday night he began frothing at the mouth and was unable to take food. The sight of strangers caused him great fright. About midnight he began barking and snarling like a dog and raved in delirium. In his struggles he bit at his friends and tore the bed clothing to ribbons with his teeth. He gnawed the footboard and posts of the bed, his teeth sinking into the hard wood. He died in the greatest agony. Consulting physicians pronounced death due to the effect of fright and its subsequent action on the heart.

Death from a Dog Bite.

A YOUTH FALLS A VICTIM TO HYDROPHOBIA OR MENTAL FEAR.

Four or five weeks ago Charles Hensey, a fourteen year old boy, who lived with his parents at No. 39 North 37th street, was bitten by a Dalmatian coach dog he was romping with. The dog had been taught a number of tricks, one of which was to jump from the ground and catch objects from the hand. The boy was engaged in this sport, when one of the dog's teeth accidentally pierced a finger of his left hand. The wound was cauterized by a physician, and, as it healed rapidly, the bite was forgotten until Monday last, when the lad began to complain of severe shooting pains in his left arm and shoulder. The boy

was employed by Mr. Taggart, a sewing machine agent at 3733 Market street, who, when young Hensey complained of the pains, sent him to Dr. Hopper for treatment. The relatives of the lad, however, objected to Dr. Hopper and sent him to an herb doctor at Bridgeport. This individual laid his hands on the boy and, giving him a cup of tea, said the respiration that would ensue would drive the poison from the system. No respiration followed the dose and the lad's relatives, being convinced that there was no poison in his system paid no further attention to his complaints until Wednesday, when he fell in violent convulsions. During the spasms which followed in rapid succession the sufferer foamed at the mouth and displayed all the usual symptoms of rabies. The convulsions were so violent on Wednesday that it required the united exertions of six men to keep him in bed. Towards evening he became quieter and at seven o'clock died. The boy is said to have been excessively nervous and sensitive and the attending physicians are of the opinion that he brought on the convulsions by brooding on the subject of hydrophobia.

Died of Hydrophobia.

Frederick Miller, thirty-four years of age and married, residing in the rear of 903 South 5th street, died at eleven o'clock Saturday night, at the Second District police station, of the most violent symptoms of hydrophobia. Strangely enough he was bitten four months ago by a small dog owned by Robert Clark, a lumber dealer, at Fifth street and Washington avenue. The dog had bitten several persons and its owner had consented to its slaughter. Miller, who volunteered to be its executioner, picked the cur up in his arms, but it squirmed and bit him severely on the lip. The dog was at once dispatched. Miller worried constantly and talked of nothing but hydrophobia, until he showed signs of being out of his mind. He became so violent on Saturday last that he had to be locked up in a station house cell for security.

Hydrophobia Again.

A YOUNG MAN'S WRETCHED DEATH.
Coroner Janney this morning held an inquest in the case of Frederick Miller, 18 years of age, who resided in the rear of No.

3517 Warren street. About three months ago the deceased was bitten by a small dog, which he had killed three days afterwards. Notwithstanding that he had the wound cauterized he was in constant fear of being effected by hydrophobia. About a week ago symptoms appeared which, although not strictly hydrophobia, were alarming enough to call a physician. Deceased complained of dryness in the throat, and evinced a repugnance for liquids. On Friday the deceased was affected with convulsions and on Saturday he underwent the horrible contortions. Once or twice he nearly succeeded in biting his mother, who was trying to calm him. In the latter part of Saturday afternoon his mother was compelled to have him taken to the Second District station house, where he died on Sunday morning. The attending physician testified that the deceased's death resulted more from fear of being affected with hydrophobia than from the actual presence of the disease, and that his death was caused by exhaustion; the result of acute mania, and the jury gave a verdict accordingly.

Died of Hydrophobia.

A CASE IN WHICH THE ACTUAL DISEASE WAS STUDIED TO ITS FATAL END.

Jersey City, N. J., December 5. One of the most interesting cases in the pathology of hydrophobia occurred here Saturday, and resulted in the death of Edward Coleman, of 269 Monmouth street this city, yesterday. The boy, a bright lad of six years, was bitten by a terrier belonging to a neighbor on October 22nd last. The dog bit Edward about the head and face in the most horrible manner. The boy was rescued and carried to a physician. Ten stitches were required for the wound in the face.

As it was not believed the dog was mad, the wounds were not cauterized. The reason for this was the terrier had suffered amputation of his tail, and it was thought the pain from the operation had made him vicious, so that when the boy called to him the animal was excited. The dog, it was afterward found, had bitten a cat and two chickens, all of them dying since from the effects. The dog was at once killed to prevent any further possible trouble.

The case was watched with close in-

terest. When the boy a few days ago began to show signs of nervous affection, his parents at once concluded to take him to the Pasteur Institute in New York city. When Edward was presented to Dr. Gibier, in charge of the Institute, an experiment was made by offering the boy some water to drink. A light spasm of the throat was apparent and on repeating the experiment the patient showed plainly the signs of hydrophobia. Dr. Gibier at once decided that there was no doubt of the case, and also that the virus had become so firmly seated in the system that inoculation would be of no avail. He advised, it is said, only a simple treatment to quiet the patient and fortify him as much as possible against the poison. The diagnosis proved correct, and the boy died at his home yesterday with all the symptoms of hydrophobia.

One of the interesting points of the case is that Edward had never heard of hydrophobia, and could not have apprehended the dreadful results. His imagination was therefore not affected and the case is purely an instance of the active force of the rabies virus.

Hydrophobia Victims.

A WELL DEVELOPED CASE—THE PATIENT BEGS TO BE KILLED.

Saginaw, Michigan, July 31. Morey Godfreg was attacked by a strange dog, July 4th. It knocked him down and bit him in several places. A few days ago he complained of feeling unwell and remained home from work. Yesterday he went into a spasm at the sight of water and has since that time gone from one convolution to another; his frenzied exertions to get away from his attendants at times required the united strength of three or four men to hold him. He barks and snarls like a dog and tries to grab his attendants with his teeth, and between the spasms begs his attendants to kill him. The doctors say it is a well developed case of hydrophobia.

A Boy Dies of Hydrophobia.

Wichita, Kan., July 31.—Robert Tannersky, aged 12, died yesterday of hydrophobia. Those who witnessed his death described it as horrible. For several hours the boy was in convulsions, and it was as much as four men could do to hold him in

bed. He was bitten months ago, but the wounds soon healed. Three days ago hydrophobia symptoms began to develop. Fear of water was the first noticed. Wednesday morning the boy had his first convulsions, but they were not bad and did not last long. Yesterday morning he was again attacked, and for hours he howled, snarled, and barked, apparently in awful agony, until death relieved him.

Afraid of Dogs in Heaven.

A HYDROPHOBIA VICTIM'S ANXIOUS QUESTIONS BEFORE HIS DEATH.

Jersey City, Dec. 6.—Mrs. Catherine Coleman, whose six year old son Edward died of hydrophobia yesterday, says the boy was conscious until the last hour before he died. He asked his mother if there were any dogs in Heaven. If so, he did not want to go there; he did not like dogs. His mother said the boy did not suffer very much. He was always thirsty and hungry during his last illness. He was afflicted with severe convulsions of the throat, which made it very difficult for him to take food.

Has the Hydrophobia.

HARRY BRASSINGTON GIVES HIMSELF UP TO THE POLICE.

New York, June 25.—A man who said his name was Harry Brassington walked

into the police headquarters at Mt. Vernon on Tuesday afternoon last, and asked the captain in charge to tie him up "for God's sake," as he was suffering from hydrophobia, caused by a dog bite he had received several years ago. The sergeant thought at first he was fooling, until suddenly he became a raving maniac. He flew at policeman Myers and would have bitten him had the other four officers who were present not interfered.

Doctor Banning was summoned and morphine injections were given him, but without any effect. He became rational again in about an hour. An ambulance was summoned and he was conveyed to the hospital. He was taken again with a paroxysm when he arrived there. When it had passed he explained to the doctors that he had suffered from the same cause before and was perfectly conscious of the danger to those who attended to him.

He said that he had been treated by the Pasteur method in this city, and had thought himself cured until on his way home that afternoon he had felt the return of hydrophobia symptoms. At a late hour last night his death was momentarily expected. Brassington is the same man who, a few months ago, was found at Harlem Bridge, suffering from hydrophobia. He was taken to the Harlem Hospital and after being treated a few days was discharged.

COMMUNICATIONS.

URETHRITIS—SIMPLE AND SPECIFIC.

I. N. BLOOM, M. D., LOUISVILLE, KY.

I have recently had two or three cases which have furnished considerable food for reflection. They were all cases of urethritis. It is now a generally accepted fact among those who are supposed to know, that urethritis is divided into three classes:

1. Traumatic urethritis.
2. Urethritis simplex.
3. Urethritis specific.

A man having gonorrhœa is subjected to specific urethritis which is brought about by the specific germ—the gonococcus of Neisser,—carried from one subject to another, and by its development pro-

duces the disease. While there have been some differences of opinion in regard to the causation of gonorrhœa, the above is the most generally accepted theory. I am not prepared to dispute this, but two cases I wish to report have at least been food for reflection for me for some time, and I propose to give the cases first then draw my deductions therefrom, or leave the members of the Society to draw theirs.

The first case came under my observation about a year and a half ago. A man who had been married about ten years contracted gonorrhœa,—at least gonorrhœa was the diagnosis given by his physician.

The following are the particulars: The man had been on a spree and had indulged in one sexual intercourse away from his wife. Two or three days after this, having no symptoms of any kind, he had connection with his wife. About a day following this coitus, he noticed a slight discharge from his penis, and consulted me. The flow when I saw it was mucoid, scarcely muco-purulent in character, about the color and consistency of glycerine. Urination on the part of the patient was painless and there was little or no inflammation around the meatus. At the end of four or five days of ordinary treatment there was no discharge at all from the penis or in the urine; in the meantime, however, for one or two days the flow became more purulent in character, but principally mucoid and remained that way until probably the end of five days when it ceased altogether. He had not practiced coitus with his wife from the time he first consulted me, and she subsequently developed undoubted gonorrhœa which lasted four or five weeks, severe in character, with urethritis, vaginitis and pelvic peritonitis characterized by the usual symptoms and usual amount of severe pain. Previous to the time this man first consulted me, he had had no signs of gonorrhœa for ten years.

The other case—rather there are two of them which are practically alike, one of which I followed very closely, having had a microscopical examination of the discharge made by Dr. Vissman—occurred in a young man twenty-six years of age who came to me about a year and a half ago for a syphilitic affection which was then about two years old. About the same time he told me of a gonorrhœal discharge he had which came on at intervals; sometimes for a week or two it would remain quiet, then become varied in form from a thin gleety mucous discharge to (at times) a decidedly purulent flow. In the course of treatment for syphilis, I saw the patient quite frequently and he paid little or no attention to this discharge, in fact the urethral discharge was only mentioned occasionally and received no direct or thorough treatment. The patient seemed disinclined to it, would not use injections nor internal medicines faithfully, and would not limit his desires or the gratification of them.

In June the man fell in love and began to think seriously of marriage. In the

meantime three years had elapsed since the development of syphilitic manifestations, to which he had attended fairly faithfully, as a man can do by getting a month's supply of medicine and taking it regularly. His gonorrhœa, from his failure to give the treatment of it proper attention, had become chronic. About the last of July, when he consulted me as to the possibility of marriage, I told him that so far as syphilis was concerned there was no reason why he should not marry, but so long as there was the slightest discharge from the urethra, this feature would debar his union. Proper treatment was then instituted and carried out rather more earnestly by the patient. In August there was some improvement, and he was still more anxious to get married. I suggested to him the advisability of having a microscopical examination made, and he was accordingly sent to Dr. Vissman with instructions to take a sample of urethral discharge when he had not cleaned out the urethra for several hours, so that the discharge could be examined. This was done, and at my request Dr. Vissman made a very careful examination, and made the following report: That while there was possibly very little danger, a few gonococci were still present, and he did not think immediate marriage was advisable as he did not consider it safe to take the risk. We then worked even more vigorously in the matter of treatment, and by the middle of September, for a week or ten days, there had been no discharge. The treatment was continued and at the end of September there was still no flow. By the first of October almost a month had elapsed without the slightest sign of gonorrhœa; the mucous shreds had disappeared from his urine as thoroughly as they ever disappear in anyone who has had gonorrhœa within five years. By a most careful examination the faintest traces of mucous shreds could be seen in the urine, but there was not the slightest evidence of discharge from the urethra, and there was nothing to examine under the microscope. I then gave it as my opinion that there was very little danger from his marrying; he was apparently in the best of health; he had been examined repeatedly for stricture, which so often follows gonorrhœa, but nothing of this kind could be found, and there was no trace of the previous chronic gonorrhœal infection.

He married early in October and (of course) pursued the usual course in those cases. November passed, and late in December he came to me stating that his wife had been complaining, and told me the nature of her symptoms. He said that she had only been complaining for a few days. He very wisely thought an examination should be made at once, and for this purpose his wife was brought to my office. Upon examination I found that she was suffering from undoubted gonorrhœa; she had urethritis, vaginitis, and considerable pain in one side, with slight pelvic peritonitis. She has been under treatment since that time; she still has vaginitis but no urethritis, and the urine has become normal. There are still some evidences of pelvic trouble in the left side.

I cite these two cases for the following purposes: In the first place we have been taught that specific urethritis runs a certain course. It has probably not been the experience of anyone here to take a case of undoubted specific (so-called) gonorrhœa, such as was present in the first case and cure it in four or five days. I remember once of having a case where I thought I was producing a remarkable

result in curing a gonorrhœal discharge in eleven days with resorcin. With that exception, I can remember no case of specific gonorrhœa that was cured inside of three to four weeks. Now, that being the case, the question is, did this man (unfortunately we did not have the secretions examined) have a specific gonorrhœa? If so, then it was cured in four or five days by remedies that have not been certain to effect a cure heretofore inside of twenty-eight days. If he did not have *specific gonorrhœa* how could he have given his wife gonorrhœa? It is fair to assume that this man has had intercourse with his wife quite a number of times since she has gotten better, and he has not developed any form of gonorrhœa.

In the second case the man had no discharge whatsoever from the urethra for several months previous to marriage, and had none up to this time, and yet his wife developed an undoubted case of gonorrhœa so far as all symptoms are concerned, because there is no form of simple vaginitis which will result in urethritis and pelvic peritonitis. I never had this woman's secretions microscopically examined.

GOUT AND THE TEETH.*

HENRY BURCHARD, M. D., D. D. S.

This paper as originally written was titled "Diseases of the Teeth with which Medical Men should be Familiar." Since, then, I have seen in the *Transactions of the Pennsylvania State Dental Society* an article by Dr. Brubaker, which deals at length with the question of reflex disturbances having origin in disease of the teeth. In view of the existence of that able paper, it would be idle to attempt extensive addition.

There are two things, however, which are worthy of the respectful consideration of every physician or surgeon. By far the most common cause of trigeminal neuralgia is some disease of the teeth. This may be the exposure of hyper-sensitive dentine; an irritation or inflammation of the tooth-pulp; any degree or type of pericementitis; and retention of fragments of

teeth after attempts at extraction. To these must be added encysted teeth, or those which have such malposition that eruption is deferred or impossible.

The dentist alone is familiar with the number of cases of trifacial neuralgia, spasmoid closure of the jaws, etc., which find relief through dental ministrations.

There is too much disposition among medical men to view teeth as little more than possible signs of hereditary syphilis, and the cause of gastro-intestinal disturbances in children; beyond this the majority of physicians do not concern themselves. This does not apply to specialists in ophthalmology and rhinology; they frequently consult with the dental practitioner for possible sources of irritation in and about the teeth.

Dr. Brubaker quotes Galezowski, that he always examines or has examined the teeth of his patients."

*Read before the Philadelphia County Medical Society, by invitation of the Board of Directors, April 11, 1894.

Certainly the most eminent men of the medical fraternity recognize what an important part the peripheral irritation, arising from dental diseases, plays in the causation of other and more serious maladies. Everyone is of course familiar with the work done by Dr. Miller, of Berlin, in dental bacteriology. There is another subject for consideration to which he calls attention—the number and variety of pathogenic organisms which find an ideal breeding-place in the human mouth. All the pyogenic cocci; those of septicæmia, of pneumonia, of actinomycosis, etc.

The more dental disease remains uncorrected, the more flourishing the colonies of these organisms.

Another matter, simple to be sure, but one in which eminent medical men have frequently erred—the distinction of diseases of the dental pulp and of the tooth's periosteum. The pulp of the tooth is not its tactile portion; it is rather that of special sense, the thermal; for thermal changes are about the only cause of response in the healthy pulp. The tactile function resides in the tooth's periosteum, the pericementum.

Teeth which respond to concussion, or pressure, have the pericementum, not the pulp, affected; in these cases the pericementum will be found dead, decomposing, or absent. *Vice versa*, those which respond to thermal change, as a jet of cold water thrown in the cavity, have the pulp affected. In the latter case, sedatives, warm syringings, and stopping are in order; in the former such measures would serve to increase the difficulty through retention of irritating materials; they require antiseptic washings, such as 15-volume solution of H_2O_2 .

After marked pericemental inflammation, abscess usually supervenes. All counter-irritation in these cases should be in the mouth, localized over the gum of the affected tooth. In these cases much damage is done, even to day, by the use of poultices.

There is a disease of the dental periosteum which has for years attracted much attention. It is known as pyorrhœa alveolaris, or better termed phagedenic pericementitis. This disease is the cause of the loss of as many, if not more, teeth than dental caries. As the name implies, it is a progressive destruction of the tooth's periosteum. Erosion of the teeth is an-

other disorder known to dentists.

The purpose of this paper is to point out the association of these disorders with the uric acid diathesis, and their striking likeness to gouty affections.

So much confusion has arisen during the discussion of papers on this subject, all due to conflicts of definition, that two will be here premised as bases to work from. They form the reason for such opinions as are here enunciated. Stress is laid upon this matter, as it is desired to point out the probability of these dental disorders being accepted as pathognomonic of the gouty disorder. Whether gout be unquestionably present or even suspected, it is confidently believed by the writer that the dental symptoms are conclusive evidence of a condition akin to, or identical with, the gouty; that its three stages—tooth induction, altered secretion of glands, and degeneration of pericementum—are expressions which receive value as diagnostic signs in the order named, representing the earliest, the stimulative; the second, the irritative; and third, the inflammatory stages of the gouty diathesis.

The uric acid condition is one arising through faulty metabolism, causing the production and retention in the circulating fluids of an excess of uric acid; followed by changes of tissue degeneration or those arising from the presence of a constant irritant in any member of the connective-tissue group. This leaves open the all-important question of the exact origin of the waste product. According to all authors, heredity plays the important part as a predisposing cause. An ingestion of an undue amount of nitrogenous food, or the increased consumption of malt liquors or heavy wines is the exciting cause. Prominent among the attendant disorders is fermentative dyspepsia, a complexus of symptoms known as portal engorgement, cirrhosis of the kidney, and subacute or chronic inflammation, or rather irritation in any of the fibrous structures.

For dental diseases. Dental erosion is a progressive loss of tooth substance through a process of decalcification, a chemical solution of the lime salts of the teeth, evidently not associated with dental caries, and which the therapeutics of caries does not check. Its action is largely confined to those portions of the teeth in contact with the labial and buccal mucous membrane.

Phagedenic pericementitis is a degeneration of the retentive apparatus of the teeth which arises without mechanical violence, specific virus, or the selective action of drugs, and proceeds to its termination with or without the formation of calcic deposits and true pus (although the pus and deposits are usual associates), the process terminating with the loss of the teeth. It is unusual to preface the pathology of a disease by its clinical history, but it will be more clear in this instance. The teeth attacked are dense and hard; the variety which resist the causes of dental caries. Men and women are alike subject to it. As a rule the disease is evident only after the patient has attained an age of thirty or over. Although it does exist in some cases before that age, its occurrence is unusual.

There are two types of this pericementitis, depending upon the portion of membrane first attacked. The more common, and as some erroneously suppose, the only type, begins as a marginal gingivitis. The earliest symptom is a deepening of color and a softening of the gum tissue at the neck of the tooth. The inflammatory appearance increases, and by the time the case receives attention the close attachment of the gum to the tooth at this point is lost. Pockets are thus formed in which are found concretions, and pus is oozing or may be pressed from the pouches. This process continues; there is degeneration of the pericementum; an inflammatory degeneration, or a molecular necrosis; increased deposits of lime salts are found as the denudation of the tooth's root proceeds. The attachment of these teeth lessens particle by particle, thus adding another source of destructive irritation, undue mobility. One by one, they lose their retentive apparatus, the pericementum, and are extruded, cast off as foreign bodies. This ends the process; there is no tendency toward extension to the maxillary periosteum. At the utmost this may be destroyed at the edges of the alveolar process and we have a slight amount of molecular necrosis at that point in consequence. The deposits are usually hard and scaly, strongly adherent. In contradistinction to the ordinary salivary calculi, they are found beneath the gum, not on it.

The disease either persists or recurs despite all local therapeusis. It is this more than for any other reason that the disease has been ascribed to a constitu-

tional cause. As for the dental erosion, we find in teeth of good structure a loss, particle by particle, of the enamel, and after this the dentine. This is in such situations that the ordinary solvent, lactic acid, produced by the action of micro-organisms is in least amount. This is the essential difference between erosion and caries. The process is usually seen when one of the superior anterior teeth is attacked. Commonly a groove or grooves may be seen, caused by a loss of enamel upon the labial faces of one or more of these teeth. The amount of enamel surface (that containing the greatest amount of inorganic matter) affected is greater than that of the dentine. This is the reverse of the process of dental caries. These spaces of denudation are in such situation, and of such shape, as to exclude any cause except that arising from altered secretion of the mucous glands about the parts. Dr. E. C. Kirk, the editor of the *Dental Cosmos*, who has devoted much time to investigations as to this condition, has found an almost constant association of it with gout.

In most cases a history of heredity and acute outbreaks. If the patient had not yet been the victim of gouty disturbance he or she did become so, sooner or later. This is for disease with an incipient expression in mucous structures.

Cases are recorded of teeth in which the tissues about the necks of the teeth are intact; and yet, disassociated from any of the usual causes of pericementitis, we see evidences of a localized inflammation of the pericementum somewhere between the apex of the root and the neck of the tooth. The disease area spreads until there is a destruction of the entire pericementum and the tooth is lost. These cases may show no evidence of the formation of true pus until near the end, when micro-organisms gain entrance through a loss of continuity of the tissues at the neck of the tooth.

Dr. Kirk has in his possession a lateral upon which there is a destruction of the apical half of the pericementum and much of the cementum; the remainder of the membrane was intact. In this necrotic area, and near the apex, was a deposit—a calculus evidently formed in the pericementum, for its attachment was so slight that it was lost. This prevented chemical analysis.

The deposits taken from these teeth have been analyzed. While some give the murexide reaction, certain others, with a clear history of gout, show not the slightest trace, being composed of phosphate of lime.

All local causes having been found insufficient to explain the course and phenomena of this particular disease, a constitutional disorder has been deemed a necessary condition for its existence. The persistence after removal of local causes assures us in such a position. Search has been made among general diseases for one which would produce a degeneration of articulative tissue with an accompaniment of crystalline deposits. In the practice of medicine but two such diseases are known—rheumatism and gout—including here as close associates of gout, rheumatoid arthritis and lithæmia. The pathology of rheumatism does not explain or agree with that of phagedenic pericementitis. We are thus driven by a process of exclusion to viewing gout as the predisposing cause. The question now is, Will the pathology of gout explain every stage of the dental disease?

Gout is hereditary in a large proportion of cases; not that this or any other disease, except in a few rare instances, is inherited, but regarding heredity as an expression of the transmission of a type of tissue. That women, who are not commonly the subjects of gout, are the victims of phagedenic pericementitis, is not an argument against gouty origin; for rheumatoid arthritis is the form assumed by hereditary gout in the female (Da Costa).

In the individual who has such a family history there is a predisposition to the formation and non-elimination of an excess of waste material of nitrogenous origin. It is rational to conceive this process as one of gradual growth; although decided manifestations of the morbid influence of the retention of these waste products do not assert themselves before middle life, the predisposition exists, and the disease process probably extends over a period before becoming recognized, the body at large resisting the morbid influence until the power of combating it is lost at some weak point or points, and the disease asserts itself. Its effects may be so insidious that our means of discrimination are insufficient to discover any aberration from an ordinary healthy

standard. Like any other general irritating substance, it may be present in any amount; all other conditions being alike, the effects are in direct ratio of the amount. Results of the action of these pathogenic materials would be most evident in peripheral parts—that is, situations where there is a scarcity of blood vessels surrounded by fibrous tissue, the least vascular parts being the first to suffer. According to the degree of irritation, we may have any stage of vascular perversion, from a slight increase in the flow of blood to the stasis which precedes necrosis; in the cellular elements, any stage from the stimulation which promotes constructive metamorphosis to the paralysis resulting in coagulation necrosis.

The most important of all questions relating to this matter is the exact mode of production of these waste products. Until it be ascertained whether this is an expression of faulty food metabolism or of an incomplete retrograde tissue metamorphosis, we are in the dark. Again, what part may be performed by the excretory organs and the oxygen-carriers of the blood. We may suspect the blood corpuscles to have a close relation, as there are splenic changes present. Apropos of this, the thyroid gland and bone-marrow should also be involved; otherwise we have grounds for the formation of further hypotheses as to the physiology of the spleen.

It is by no means clear what influence the liver has in the production of gout. One would infer from a reading of some of Lauder Brunton's works that he suspected that organ to be largely at fault. It is presumed that any body—any crystalline substance—resulting from causes similar to those producing uric oxide would have analogous action. We know that xanthin, or, as it has been called, urous oxide, does form nuclei of cystic calculi.

Inflammation of fibrous structures arising from such source are, perhaps, more common than supposed or conceded. The presence of an irritating product, such as uric acid, even in slightly increased amount, could produce widespread disorders of a not severe type, and render inexplicably obstinate many disease processes usually amenable to treatment.

For purpose of comparison as to the active diseases, general gouty condition,

and marked phagedenic pericementitis, Ebstein's theory fits best. It is a nutritive disturbance first, leading to necrosis; and urates are deposited in the necrotic area.

For the minutiae of the dental trouble, first, the unusually hard and dense teeth, very commonly the subjects of pulp calcification. Accepting the uric acid diathesis to be a condition long existent, there will be for some period present in the circulatory fluids an excess of the irritating waste product, uric acid. From this there will be structural alterations in peripheral parts. Stimulation of the peripheral cells of the dental pulp is followed by an increased deposit of calcic material, necessarily lessening the amount of organic matter present. The density of the dentine increases; its vital parts decrease. This may continue until scarcely any vestige of vital matter is left within the teeth. They become of the variety which resists dental caries. The cirrhotic process affects the parts about the teeth; the alveolar process increases in density; the thickness and elasticity of the pericementum decreases. In this connection it would be a matter of great interest to note the structure of the teeth in young patients who have a family history of gout.

At a period during or approaching middle life, the gouty condition being present, it will manifest itself in one of two ways, the intensity of the action depending upon the amount of irritating material present and the amount of resistance offered by different tissues. Altered secretion is regarded as a milder form of disorder than tissue change. Function, in the majority of cases, is altered before structure. The presence of waste material will cause, in peripheral glands, irritation during its elimination. There are numerous mucous glands in the labial and gingival mucous membrane. These may secrete an acid capable of acting as a decalcifying agent upon the lime salts of the teeth; this would explain the phenomena of erosion.

Function is in correspondence with structure; teeth of this type are designed for hard, vigorous usage. From their structure they are exposed to two probable sources of debility; one, that they may become through their lessening vascular supply of the nature of bodies foreign to the structures which support them; the other—it is questionable if, in civilized

life, 90 per cent. of persons give their teeth sufficient use in view of this fact; for teeth of this description doing the amount of work their structure demands is out of the question. More than this, gouty patients are frequently gourmands, and indulge in food requiring little mastication.

Disuse and misuse are two prominent sources of debility in any part of the organism. The vital parts of such teeth will, therefore come to a state of agony through disuse. Their resistive power to morbid agents will be weakened. Disease attacks preferably a weak part; rather, a weak part permits the existence and growth of the causes of disease. According to the evolutionist definition of life it is questionable whether a perfectly healthy part can become the subject of disease. These organs are, therefore, in fit condition for the development of disease process, through their acquired debility.

The teeth and their attachments to the alveoli form articulations; the pericementum is the periosteum of the tooth's root, and the ligament which binds it to the bony walls enclosing it—the type of tissue for which the gouty poison seems to have selective action.

According to Ebstein, the gouty process is essentially necrotic. This is in marked gout, but there must be every stage of vascular disturbance antedating the necrosis. According to the degree of irritation will be the effects. Every medical man has seen gouty attacks, ranging from a slight metatarsal-phalangeal arthritis to the variety accompanied by excruciating pain, followed by deposits in the joint. So with the teeth, the phagedenic pericementitis may be an inflammatory degeneration or a necrosis of the fibrous—in fact, of all the articulative tissue. The waste matter is now in amount sufficient to produce structural degeneration. An early angiomatic change will be a swelling of the intima; this, in small vessels, will markedly impede, if not check the flow of blood. The tissues are starved, and to the extent of innutrition there will be either inflammatory degeneration or molecular necrosis.

For the deposits, preceding their formation, there is an acid reaction in the necrotic area; the blood having lessened alkalinity, through the presence of an ex-

cess of uric acid, a substance insoluble in acids meets the acid tissues and uric acid or urates are deposited. As before mentioned, the tests for uric acid did not always, nor frequently, demonstrate that substance to be present in the dental deposits. These, as analyzed by Dr. Kirk, are frequently found to be phosphate of lime. It is probable that a small crystal of a urate has acted as an irritating point around which the calculus has formed. The deposits at the necks of teeth, just beneath the free margin of the gum, do not resemble ordinary salivary calculus, or the deposits which are found near the apices of the teeth. Their probable origin has a close connection with the secretion of the mucous glands, which lie just within the border-line of the gum. As the disease progresses these encroach more and more into the area of necrosis, or their presence forms the continued irritation which determines the persistence of the disease.

As before stated, there are cases where we have no visible signs of pus. If the disease begins at the gum margin pus is probably always formed; the analogous phenomenon of gout is the tophic abscess. Several pathogenic cocci have been isolated, but there is absolutely no evidence that the disease has such a cause.

For a summing up. There is a dental disease for which local explanations as to cause do not suffice. George B. Wood, Niemeyer Garrod, Duckworth, and Bartholow, among medical men; Marshall, Peirce, Kirk, Jack, and others, among dentists, note the association of the disease with gout; in very many cases a clear history of heredity and acute outbreaks. Search has not been thorough in certain instances to determine whether or not obscure gout be present. Other cases show decided evidence of lithæmia. After the removal of all visible sources of local irritation the disease of the teeth either persists or recurs after some lessening of the severity of the local symptoms.

Some of the cases recorded by the dentists named are as follows: The teeth of certain individuals, with or without a definite history of gout, become susceptible to periosteal irritation, even an inflammation, and this in the absence of the usual local irritants.

The ingestion of an undue amount of nitrogenous food or heavy wines is fol-

lowed by one of these attacks of pericementitis. Upon a withdrawal of these substances from the dietary, there is a disappearance of the local inflammation.

There is but one deduction from this: the disorder must be due to faulty metabolism.

We have a local inflammation, due to the formation and retention of what should be waste product; and what more is gout?

There are two elements—one a faulty metabolism; another, the organs of excretion do not functionate properly. As far as we have evidence, the latter seems to be the element which determines an attack of gout.

Faulty metabolism might, and no doubt does, cause the formation of incomplete oxidation products, and these excite disorders of a mild type in many, very many persons; but it is only when the organs of elimination have reached and passed the limit of their function that weak parts give way, and an explosive attack of gout results.

There is no reason why any member of the same group of substances might not play the irritant role; xanthin or urous oxides, uric acid or uric oxides, in excess they are both irritants. Pathological chemistry certainly gives but meagre account of the origin of both substances.

In about 75 per cent. of cases of true phagedenic pericementitis, dentists give an unfavorable prognosis, and despite all local measures of therapeutics results justify such an opinion.

This fits Ebstein's theory of gout, the process essentially necrotic. In any disease a prognosis is favorable to the extent to which cause may be removed and effects remedied. Both these objects are difficult or impossible of attainment thus far in the dental disease.

As for the question of therapeutics. A condition in which there is altered secretion, necrosis of certain connective tissues, with a consequent undue mobility of the teeth, the presence of necrotic material, and more or less of foreign bodies; added to these, the continuance of a predisposing cause which is also acting as an excitant. The indications are, of course, the removal of all the causes; a cure cannot be effected while any of them persists. All dead and foreign materials are to be removed. All bacteria to be destroyed,

and their further action made difficult or harmless. Faults of occlusion are to be remedied; loose teeth so fixed by splints that rest of the loose organs is assured. Local vascular disturbance is to be controlled. This is as far as local measures can be carried, and the daily experience of dentists demonstrates it to be insufficient.

General treatment involves the correction of the secretion of glands of the parts about the teeth. This evidently can only be accomplished by a removal of the causes which give rise to the formation of incomplete waste products.

The gastric and intestinal catarrh must be corrected; as the gastric disturbance is of the fermentative type, a lessening of the amount of carbohydrates in the dietary is quite as important as modifying the type of the nitrogenous ingesta.

Many of the cases gave evidence of the condition known as portal engorgement. Whether affection of this organ is the primary cause of the faulty metabolism, is a question of the utmost importance. The changes in fibrous structures at large, such as in the tissue beneath the bronchial and pulmonary epithelium, in the connective tissue of the kidney, etc., are not within the province of our special therapeutics. Certainly the general indication is the elimination of the retained, irritating waste product. How else does colchicum act? Many symptoms are relieved by producing an increased alkalinity of the fluids of the body. In some situations concretions are removed through the solvent action of lithium salts, but it is out of the question to hope for such a result with dental deposits. The tartrate of potassium and sodium is one of agents used for the double purpose of producing alkalinity of the circulating fluids, and as an eliminant through the *prima via*. This fact has suggested to Dr. Edward C. Kirk the advantages of replacing one of the bases of this tartrate by lithium; a lithium Rochelle salt is the result. The virtues possessed by this compound over the usual lithium salts and the officinal Rochelle salts is evident. While it performs the office of the tartrate in bringing about an increased alkalinity of the blood, there is added the uric acid solvent, lithium. It has a mildly laxative effect. Where it has been tried there has ensued a speedy amelioration of the annoying symptoms of lithæmia due to clogged excretion.

Dr. Bartholow calls attention to the value of manganese salts in the treatment of the gouty condition. This aids first in a correction of the gastric disorder, and secondly, as in the case of permanganate of potassium, increases the oxidizing function. Iron should, therefore, be doubly useful in the anæmia of the gouty diathesis. In this connection, is it not possible that certain obscure maladies, relieved through the inhalation of oxygen, may be cases of obscure gout, masked lithæmia?

IN a public address in England Lord Coleridge told an anecdote of Browning that gives an interesting glimpse of the poet's self-appreciation. Browning sent the jurist a copy of one of his later books of poems, and when he asked for an opinion of it was told frankly, "What I understand I heartily admire, but there are parts which for the life of me I can't understand." "Ah, well," replied Browning, "if a reader of your calibre understands ten per cent. of what I write, I think he ought to be satisfied.—*New York World*.

PAIN WITHOUT FEVER, says a prominent physician, may be very severe, and may cause much suffering, but in acute attacks it is not dangerous. "If you had this amount of pain that you complain of," he said to a patient who had hastily summoned him, "in any inflammatory disease, you would be in a raging fever; if you have no fever you need never worry." Most serious illnesses are preceded by a chill. This is a symptom which should never be disregarded, and it is always safest to put a child to bed and stop its food. Warmth and dieting will be found to be the best remedy for any ordinary indisposition, while for the beginning of any serious trouble it is often the only thing that can be done until the disease declares itself.—*Good Health*.

AN UNUSUAL OCCURRENCE.—Mr. Hudson Rivers—"I suppose fights are of very common occurrence in your native town."

Colonel Longhorn—"Yes; there is so much fighting that when a disturbance of some kind is not taking place large crowds gather to see what is the matter.—*Texas Siftings*.

TRANSLATIONS.

THE SACRAL METHOD FOR EXTIRPATION OF THE UTERUS.†

Dr. Hochenegg contributes some interesting facts to medical literature on the above subject. During 1885, Kraske performed a resection of portion of the sacrum in order to facilitate extirpation of the rectum; he named this method "Sacral Rectum Extirpation." Later (1888) Hochenegg and Herzfeld decided to utilize this method in selected cases for uterine extirpation instead of performing it *per vaginam* or by abdominal section.

Dr. Herzfeld presented a paper on "Sacral Extirpation of the Uterus" at the Gynaecological Congress held at Breslau, May, 1893, which called forth a lively discussion, and in which the majority of German gynaecologists opposed its adoption.

Hochenegg, in this present contribution, is anxious to prove its usefulness in certain selected cases, and reports from his practice 25 cases in which the sacral method was used to extirpate carcinomatous uteri; in most of these the disease was so far advanced that extirpation *per vaginam* would have been impossible; there were four deaths due to the operation.

A collection of other reported cases found in medical literature number 98, with a total of 18 deaths, or a mortality of 18.3 per cent.

The convalescence is somewhat prolonged (6 to 8 weeks) in comparison to other methods. The points in favor of the sacral method are: That the field for operation is more accessible; any bleeding vessel can be readily and securely tied; the large blood vessels are easily isolated and tied, and the ureters avoided. Many cases which are hopeless for the vaginal method can often be radically removed by the sacral method,—for instance, such in which the bladder and intestines have become implicated, or such where isolated carcinomatous deposits could be found in the parametrium, or fibroids and ovarian tumors necessitated removal.

In a contracted pelvis or vagina in which there is a carcinomatous uterus with pyo-salpinx or ovarian abscess, the sacral method permits of greater accuracy and facility in their removal.—*Med. Neuig.*, No. 15, 1894. —W.

SYPHILIS TREATED BY INTRA-VENOUS INJECTIONS OF SUBLIMATE.

Prof. Baccelli highly recommends this form of treatment after having given it a fair trial in the clinics as well as his private practice, particularly in such cases in which the ordinary methods have produced little or no curative effects. The solution used by him contains the following:

R:	Hydrarg. Bichlor.	10.
	Sod. Chlor.	3.0.
	Aq. Dest.	1000.0.

The skin is thoroughly disinfected, and the veins made prominent by previous bandaging, the needle of a hypodermic syringe is introduced into the selected vein and the fluid injected. The cure begins with one daily dose of one milligramme or one cubic centimetre of the 1:

1000 solution. This is increased to 2-3-4-8 mgrms.

The author gives the following reasons for the adoption of this method as an improvement on others:

1. The necessity of using the smallest dose necessary to effect the desired cure, and which is not always achieved by the hypo- and endermic methods.

2. The possibility of overcoming rapidly such symptoms due to direct blood poisoning from the syphilitic virus.

3. The prompt and general action upon the walls of the blood vessels, which is a particularly favorite seat for syphilitic changes.—*Med. Neuig.* 1894. —W.

† Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

THE Modern Pawnshop: Give the devil your time and he will lend you trouble.

TREATMENT OF ECLAMPTIC ATTACKS IN CHILDREN.

The child should be placed in bed, the room thoroughly aired, a careful examination made with a view to finding the cause; a mixture of a teaspoonful of salt, 3 or 4 of oil to one glass of lukewarm water, used as an enema; if the mouth can be opened it is well to touch the fancies with the feather edge of a quill, and give a quickly acting purgative. Should the attack continue in its severity, the following mixture is used as the first was:

R	Mochi.....	0.2
	Camphor.....	1.0
	Chloral Hyd.....	0.3—1.0
	Vitell.....	1.
	Aq. Best.....	150.

M. Sig. Used as an enema.

Also a mustard bath, quarter to half hour; during severe convulsions chloroform may be carefully administered; between the attacks absolute rest is indicated and the administration of the following mixture:

R	Zinc. Ox.....	1.0
	Hydrarg.....	
	Valerian.....	55 5

M. ft. Puv. Div. in part equal No xii. Sig. Two powders daily before meals.

—*Med. Neuigkeit.* No. 15, 1894. —W.

IF thy foe be as small as a gnat, fancy him as large as an elephant.—Ex.

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

MEDICATED TENTS FOR CANCER OF THE UTERUS.

Dr. Ch. Jennings (*La Semaine Médicale*, No. 23, 1894) recommends the employment of a medicated tent of the following composition, in treatment of cancer of the uterus:

R	Methyl Blue.....	
	Tannin.....	55
	Powdered Opium.....	25 (grs. iv).
	Olive Oil.....	25 (grs. 3%).
	Cacao Butter.....	45 oo (3j. 5d.)

Sufficient for one tent. Introduce one every day into the cervical canal, keeping it in place with a tampon.

LACTIC ACID IN TUBERCULOSIS OF THE BLADDER.

Dr. Witzach (*Hospitals-Tidende*, No. 10, 1894) speaks highly of instillation of a five per cent. solution of lactic acid in patients with tuberculosis of the bladder, especially in those cases where an operation offers but little hope of improvement, or is refused. He has employed this treatment in five cases; in three of these there was a remarkable improvement, while in the other two the action was less pronounced. In order to prevent the pain of instillation he later came to use a combination of lactic acid and cocaine—cocaine lactate—which is a syrupy fluid. Twice

a week he instilled a gram—fifteen drops—of the following solution:

R	Lactate Cocaine.....	1
	Lactic Acid.....	
	Distilled water.....	55 5 o (3j. 5d.)

A TONIC PILL.

In the (*Revue Médicale*, March 18, 1894) the following formula is presented as a serviceable tonic pill:

R	Extr. Cinchona.....	
	Extr. Kola.....	55 5 o (3j. 5d.)
	Extr. Rhubarb.....	2 50 (grs. xxxvij).
	Extr. Nux Vomica.....	o 50 (grs. viij).
	Arsenite Iron.....	o 20 (grs. iiij).
	Powdered Kola Nut.....	Q. S.

Sufficient for one hundred pills. Two at each meal.

ASTHMA.

Dr. R. v. Rokitanaki (*Norsk Magazin for Laegevidenskaben*, No. 4, 1894) praises the following formula, in asthma:

R	Chloral Hydrate.....	
	Iodide Potash.....	55 2 o (grs. xxx).
	Water.....	150 o (3ivss).
	Syrup Orange Peel.....	20 o (3v).

Two to five tablespoonfuls a day.

ACUTE OR CHRONIC CORYZA.

Dr. L. Dessar (*La Semaine Médicale*, No. 23, 1894) recommends the following powder as a convenient and efficacious snuff, in acute and chronic rhinitis:

R	Starch.....	3 o (3j. 3d).
	Powdered Boric Acid.....	3 o (grs. xiv).
	Subnitrate Bismuth.....	3 o (grs. xxx).
	Menthol.....	1 o (grs. xv).
	Tannin.....	20 (grs. iiij).
	Muriate Cocaine.....	55 5 (grs. j.).
	Aristol.....	

* In charge of the Translator, F. H. Pritchard, A. M., M. D.

CORRESPONDENCE.

PARIS AND HER HOSPITALS.

[FROM A SPECIAL CORRESPONDENT.]

Before the last ill-fated war for France, with Germany, when the last Empire was at the zenith of its glory, Paris was generally regarded as the most important medical centre of the world. The shadowy halos of the immortal Bichat, Lavoissin, Magendie, Dupuytren and many others who adorned their profession and have left their foot-prints on the sands of Time, yet lingered on the horizon and their immediate disciples had cast a fresh glamor over the memory of their departed masters. France was rich and prosperous. Her parks, boulevards, museums and numerous palaces were great attractions to the foreigner. All the sciences cognate to the healing art were taught by many whose names have since become world-wide; clinical material was abundant and for the first time microscopical pathology was placed on a sound and enduring basis.

Living in Paris was not expensive to the student of moderate needs; the climate was mild, and the language, to one at all familiar with the classics, was comparatively easy of acquirement; and what was most coveted of all, was that one might say he had "studied at Paris."

But in 1870, France sustained on the battle-field a most humiliating defeat and was compelled to pay a war indemnity of five billions of francs.

Now the tide turned, and her rich and victorious neighbors across the Rhine soon made such lightning strides in medical science as to attract the notice of the whole professional world. Everthing French became unpopular and students from abroad came to France only to pass through on their way to Germany. In America the German language was soon taken up. German medical literature became popular, so that to-day, but few at all advanced in the profession fail to speak the Teuton with ease and fluency.

But now France has recuperated once more; her medical schools and hospitals are abundantly equipped with everything that modern times necessitate for the successful acquisition of a sound knowledge of the healing art.

During a recent tour through the hospitals of Paris every courtesy was extended to us to visit the lecture halls, the extensive laboratories, wards and operating theatres.

What concerned us the most was the general construction of the hospitals, the hygienic surroundings, the care and diet of the sick, surgical innovations, dressings and appliances.

Opportunity was afforded to especially inspect the new *Hôtel Dieu*, *Charité* *Necker* and *Sal Petrière*.

The principal hospitals of Paris are noted for their large and numerous court yards, open spaces, areas and commodious verandas. They are well lighted, drained and ventilated.

Like the German, the Frenchman is proud of his *consommé* or soup, and wine enters largely into the hospital regime. Coffee is drunk strong, in small quantities and without milk. The French drink little or no tea.

The nursing in most of the hospitals there, as in London, is conducted principally by religious communities of ladies. For a time after the downfall of the Empire, the sisterhoods were all expelled from the hospitals, though in a short while hospital managers found that lay-nurses were insubordinate, unsatisfactory and very expensive.

A Frenchman on entering a Parisian hospital relinquishes none of his liberties, and must in all cases give his free consent before any description of serious operation is undertaken on him. It strikes one as rather amusing to see a patient sitting up in his bed smoking his cigarette or pipe, but in this city the picture is so common that no one notices it, except the stranger.

The Hospital *Sal Petrière* is a vast institution, consisting of a large number of vast buildings and pavilions, and covering a very large area. Since the death of Charcot the place presents a deserted air. His private consulting rooms are yet just as he left them. The empty chair, the emblems of mourning and the general atmosphere of gloom which pervades his lecture-theatre, all tend to convey a most

melancholy impression and make one feel uneasy until he is out in the open air once more.

Nothing new or startling was observed in surgery, yet there were evidences of advances in antiseptic details and more elaborate preparation for capital operations than were observed but a few years ago.

As a rule the French surgeons are clever anatomists, skillful, neat and rapid operators. As yet the general surgeon maintains a tenacious grip on gynaecological work, and until recently, since Pozzi has opened a special hospital for gynaecological cases, all this class went to the general operator.

It was the experience of the writer that France and England are conspicuously conservative in surgical operations. The craze to laparotomize for everything seems to have spent itself, and one sees now fewer abdominal sections for exploratory purposes, than formerly. Nevertheless they seem still to practice radical operations for every type of hernia, notwithstanding Segord's condemnation of the operation for any except complicated and unusual ruptures.

In the Hotel Dien, a considerable number of cases of severe compound fractures were seen, and it was of great interest to note the number and diversity of ingenious devices and contrivances which were utilized in their treatment. Conservatism in all traumatic bone lesions is carried to great lengths in Parisian hospitals. The doctrines and manual of M. Ollier, of Lyons, appear to have been adopted practically in their entirety. No limb is ever sacrificed after an injury, until every resource is exhausted to save it or some part of it, and every portion of the periostium is preserved with greatest care.

Cocaine is probably employed in the hospitals of this city more freely than in any other in Europe. Practice and experience have enabled the operators now to administer it in such a manner that its technique is simplified, and its action is as prompt as it is efficient in that class of cases most appropriate for its employment.

Antiseptic surgery is still practiced here in orthodox fashion, and there is no evidence of the doctrine losing ground or becoming unpopular. On the contrary, surgeons look on this preventative as their sheet anchor.

Quackery is rampant in Paris though, perhaps, they have not as many faith-healers and itinerant impostors as we have in America; yet there is a larger proportion of regularly educated physicians who, weary of the restraints imposed by the regular profession, boldly announce their wares through every sort of advertising medium. And why should they not, when the venerable scientist, Brown-Sequard, is the greatest sinner of them all? Everywhere, on lamp-posts, in urinals, in railway stations and in the most out-of-the-way places along railroad lines, in every direction, one will see large banner posters advertising the "*Suc du Brown-Sequard; tres precieuse*," etc., for nervousness, diminished sexual power in men or women, old or young.

This is the Easter season, during which time medical students are given a month's vacation. No didactic lectures are delivered, and there are no clinics except for the performance of those operations which cannot be held over until the schools reopen.

T. H. M.

A DUMB SECT IN RUSSIA.—One of the deluded sects in Russia is the "Dumb Boys." Why they are called Dumb Boys no one seems to know, but it is a curious fact that the sect is composed of both sexes, old men being in the majority. It is asserted that some of these aged patriarchs have not spoken in fifty years, although perfectly able to do so did they so desire.—*Philadelphia Press*.

A PORK-PACKING company in Chicago arrested a half-starved man for biting a piece of pig's foot. Its value was less than two cents. The man was imprisoned, and, when released, found that his invalid wife had become insane and his helpless little children could nowhere be found. Had the poor man succeeded in stealing the entire establishment, he would doubtless have taken rank as an "operator."—*New York World*.

A LITTLE child laboriously prepared an Easter gift this year for her saintly grandmother. It was a cardboard motto selected by herself, and bore the words in scarlet worsted, "Go, and Sin No More."—*New York Times*.

THE MEDICAL AND SURGICAL REPORTER

ISSUED EVERY SATURDAY

Address care P. O. Box 843, Philadelphia, Pa.

HAROLD H. KYNETT, A. M., M. D.
Editor

RODERIC C. PENFIELD
Publisher

147-149-151 North Tenth Street, Philadelphia

TERMS.—Three Dollars a year, strictly in advance. Sent four months on trial for \$1.00.
REMITTANCES should be made payable only to the Publisher, and should be made by Postal Note, Money Order or Registered Letter.

NOTICE TO CONTRIBUTORS.—We are always glad to receive articles of value to the profession, and when used they will be paid for, or reprints supplied, as the author may elect. Where reprints are desired, writers are requested to make a note of that fact on the first page of the MS. It is well for contributors to enclose stamps for postage, that the articles may be returned if not found available.

SATURDAY, MAY 19, 1894.

EDITORIAL.

THE GENEROUS PROFESSOR AND THE PRODIGY'S RETURN.*

In a certain city, called the City of Brotherly Love, there dwelt many wise men and those having knowledge of the things that pertain to theology, to law, to medicine and to all things wherein men are learned.

There were also many great schools wherein was taught all kinds of knowledge.

And the fame of these schools and the wisdom of the learned men was very great, insomuch that the report of them spread abroad throughout all the world.

And it came to pass that a certain physician who was held in much esteem, fell sick of a grievous malady and was gathered unto his Fathers.

And there arose great lamentation throughout the city.

Then certain of the sect of professional philanthropists who are called promoters (for this sect professes that the relief of the needy can be done in none other way than by assisting individuals, and hold themselves ever ready to be used as examples of

their faith) took counsel together as to what they should do.

For they were sore distressed, crying, Woe unto us! How is the mighty fallen! And there is none to take his place.

For we have searched and, behold, there is none, no not one among all the four hundred who wear the phylacteries, who can fill the sandals of him who is departed.

And they rent their raiment and put on sack-cloth and ashes and cried aloud exceedingly.

Then there arose one among them, and spake unto them saying: Men and Brethren hearken unto me. Why sit ye here mourning. Arise now, put off your sack-cloth and clothe ye yourselves in your right minds if, peradventure, ye have any.

Know ye not that the present is a great time for professional philanthropy?

Ye say, and ye say truly, there is none among the four hundred who have the phylacteries who can fill the shoes of the departed.

But verily I say unto you there is one who dwelleth in a far country which is

* Fragment of a record exhumed from a modern tumulus.

famous for the greatness of its inhabitant's footgear, who is willing to put on these shoes if he is able.

For I say unto you he is a Prodigy.†

Now, therefore, let us send unto him and beseech him to come and dwell among us and wear these sandals, that we may no longer be bereft.

And if so be that he is not able to put them on, behold there is at hand a retreat wherein he may be fed and clothed until such time as he be grown to fit the shoes.

Thus shall we aid the needy and show forth the glory of philanthropy, that all men may know that of Faith, Hope and Charity—the greatest of these is charity, which suffereth long and is kind, and cōvereth a multitude of "skins."

And they all agreed together, marvelling much that one of their number could so devise, for professional philanthropists are not accounted wise or learned.

And they indited epistles to the Prodigy beseeching him to come and help them, saying, All charges will be paid at this end.

And they sent the letters safely by servants of the government.

And it came to pass when the letters were delivered unto the Prodigy, that he read them and gave heed unto them.

And he took counsel with himself saying, Lo, here is a snap! Behold, I have dwelt in this land these many days, waiting to build sandals large enough to wear in years to come and have not yet secured an estimate.

And behold, I am entreated to go hence and, in an ancient city, wear the greatest pair—for so he had been told.

Moreover, all charges are prepaid, and there is a mansion waiting wherein I may reside the while these shoes are being half-soled and heeled.

Now, therefore, I will arise and will go unto that city, I and all my family with me, that nothing may be left to show I ever lived elsewhere.

† Or Protégé. As is evident from the context the two words are used as synonyms in the original.

And he arose and did as he had said.

Now it came to pass when he arrived in the City of Brotherly Love, that great misfortunes came upon him because that the professional philanthropists, though endowed with shrewdness, had not common-sense.

For it so was that the sandals which had seemed so mighty unto them, were far too little to be worn by many men who deemed it shame to wear phylacteries.

Likewise they reckoned without cause, in that the Rulers of the chosen retreat would none of the Protégé.

Saying, Go to! This business is not yours, nor can ye meddle with it.

Thus was the Prodigy put in sore straits, for he had not wherewith to house nor clothe himself, neither had he ought to eat or drink, save what was given him.

Now there was in that city, a righteous man of profound learning, who was also a teacher in one of the great schools of the city.

And such was his wisdom and skill and his kindness of heart, that he was greatly beloved of all that listened to him.

Likewise, his learning was set down in books, and his name was spoken as one having authority, even in the uttermost parts of the earth.

And men came from every nation to be taught by him those things which must be known in order to heal the sick and minister to the afflicted.

And among all the great men in that great city none was mightier than he.

And it came to pass when he knew of the afflictions of the Prodigy he was moved with compassion.

For he said, Surely I have known the struggles and misfortunes of a young man. And as I was given strength wherewith to triumph in my hour of need, so will I give my aid to those who need it.

By this he showed that he was not of the sect of professional philanthropists.

So he came unto the Prodigy and taking him by the hand he lifted him out of

the mire and put his feet on solid ground.

And he entreated him well and took him to his own place.

And when he had looked upon him and found him fair to see and possessed of good parts, his heart was warmed within him, and he made room for him at his own side.

And he spared nothing to spread abroad the name of the Protégé and to make for him a place among the learned of the city.

And because of his efforts the Protégé thrived and waxed fat and, in the fullness of time, he kicked.

Then was shown a mighty wonder on the face of the earth.

For it came to pass that he whose sandals were to cover all the land, increased not in his understanding though his head swelled beyond belief.

And he took unto himself foolish counsellors who said those things they thought would please him, rather than the things of righteousness.

And he listened to them until he boasted himself there was not another such an one in all the earth.

For he said unto himself, Behold me, what I am.

For am I yet a youth or am I come to manhood? Is it not time that I should show all men my greatness?

Was I not besought to come hither and let the light of my countenance shine upon those men more foolish than myself?

Did I not come and get my foot in it?

Yea, verily, not only my foot, but my whole body and my head, yea, even to the tips of my ears.

What though I was pulled out by one esteemed so great, is not the honor of helping me sufficient reward for any living man?

Verily he hath done himself credit in honoring me, but that I may not seem ungrateful I will accord him honor worthy of the Dwellers of Olympus.

For I will accept all the great and solid glory he has built up by a life-time of

righteous deeds and pure wisdom, and use it as my pedestal, which all men, viewing from afar, will think to be my work.

And I will place him on a shelf where he may see and yet remain unseen, and he shall revel in the happiness of seeing men applaud his work, believing it of me who am so great.

When he had made an end of thinking, he cast about for means wherewith to do his will.

And he gathered together certain who considered it wicked to withhold their greatness from men who wot not of it.

Certain others also who possessed talents bearing the stamp of the government which made them legal tender for all things, save only brain and conscience.

And others likewise, who had sons or kinsmen not born great nor able to achieve greatness and upon whom they desired to thrust greatness.

Others also belonging to the sect of sore-heads and growlers, together with the professional philanthropists and all the dwellers in the holy land who love to sit in the high places and be seen of men.

These then took counsel together and joining all their wants, they went unto the Rulers of the great school and demanded of them the removal of the Pitiful Professor, together with three others who are likewise men of great reputation and teachers of ability, and to give their places to the Protégé and others like unto him.

Now, therefore, if the Rulers of the school hearken to these cunning men and are persuaded of them, the meaning of this parable will be made manifest to all men.

But what think ye those Rulers—

[The record is abruptly broken at this point, and we are left to conjecture whether this fragment is a prophesy, an admonition or an allegorical statement of current events. Further research will undoubtedly supply the missing parts and develop the sequel.]

SOCIETY REPORTS.

THE LOUISVILLE SURGICAL SOCIETY.

February 7, 1894.

[Stenographically Reported by C. C. Mapes, M. D.]

CYSTIC TUMOR OF THE ORBIT.

DR. W. O. ROBERTS: This patient is sixty-one years of age. Forty-five years ago, that is when sixteen years old, he was kicked by a horse just above the brow, receiving a compound fracture of the outer table of the skull. He says that the brow seemed to be knocked down. The attending physician told him that the inner table of the skull was no injured. The wound healed, with marked depression at the seat of the blow. He had no trouble following the injury with the exception of headache; there was never any indication of epilepsy or anything of that kind. There was some defect in his vision, and he claims that his eye on that side was pushed down somewhat.

Twenty-nine years ago while chopping wood, a stick flew up and struck him on that side of the head, two splinters being driven into the eye-ball; a large piece struck him just above the eye, and he thinks pushed up that part of the brow which was forced down by the kick of the horse. The splinters which penetrated the eye-ball had to be removed by his family physician.

Two or three months after receipt of the last blow a tumor made its appearance just above the eye and near the nose, and, as he says, it pushed the eye considerably down and as it grew larger it extended to the right side, and has attained the size which you see now, being much larger than a man's fist. There is very little vision in the eye on that side; he is able to distinguish daylight from darkness, but nothing further. There has never been any acute pain from the growth.

DISCUSSION

DR. TURNER ANDERSON: I think the tumor is unquestionably cystic. In regard to the origin of it there is one point of interest to me in connection with the ridge of bone passing around the tumor, which is especially plainly marked at the upper portion. Wherever the pericranium is elevated, as we find in cases of bloody tumors in the head of new-born children, where the effusion is underneath the pericranium, between the bone and the covering of the skull, the pericranium being elevated, it very soon begins to throw out a line of bone and within a few days the blood seems to be contained as within a cup, the line of bone having ex-

tended all the way around it. These cases usually recover without treatment.

In the case before us I take it that the tumor is clearly cystic; the pericranium has been elevated by the effusion, and the imperfect line of bone at that point formed before the vessels became so thoroughly constricted that new bone could not be produced.

DR. W. L. RODMAN: The case is certainly very interesting, and Dr. Roberts should have it photographed before he operates. There occurs to me three possible views in the case: First, it is possibly a dermoid cyst, for it occupies one of the favorite regions of the body for such growths. While dermoid cysts are congenital, they very often do not make their appearance to such extent as to be noticed until advanced life. They are more common near the outer than the inner angle of the orbit, although they do not occur in both situations.

Secondly, it may be a cyst which is growing from the frontal sinus.

Thirdly, it may be a cyst growing from the bone, probably the upper part of the wall of the orbit. It seems to me this view would be the most rational and more in line with the symptoms present in this case. In any event I am perfectly satisfied that it is a simple cyst. It could not well be malignant. Its duration, absence of pain and glandular enlargement, together with the excellent general condition of the patient emphasize the innocent nature of the growth. The irregular edge I think is due to the fact that the anterior or outer table is gone. I believe that the bone will be found necrotic. It is a simple cyst; probably dermoid in nature, either beginning at the angle or the roof of the orbit, and I believe operation should be performed at once.

There is another possible view of the case, which, however, is hardly probable, viz.: a sub-dural cyst. I operated upon such a case occurring in a negro boy at the University Clinic in 1889, Dr. Ray assisting me. Both the cyst and eye were removed and the case made an excellent recovery.

DR. J. M. RAY: It seems to me that the starting point of the growth before us is in the frontal sinus. The history of the growth beginning at the upper and inner angle growing toward the outer corner, looks very much as though the probable origin was in this local-

ity. Fatty tumors about the orbit are quite common, both congenital and otherwise. I have seen several such cases.

DR. A. M. VANCE: I do not think the growth before us is cyst; the contents seem to be semi-solid, and I believe it commenced in the orbit proper, from the history. I believe the orbit will be found to have melted away, also the bone above it has given way allowing the tumor to grow upward.

I do not see why it may not be malignant. I know that I have removed sarcomata from the head of people who looked just as healthy and in just as good condition as this man presents, which had been growing almost as long. I am inclined to think that this growth, if not originally malignant, is at present. I believe its contents is not fluid, but semi-solid. I certainly recommend its removal.

DR. W. O. ROBERTS: I have very little to add in closing. There is some question in my mind whether it is a cystic tumor, or a myxo-sarcoma. I think it comes from the orbit, and I told this man when he came to my office to-day that I thought it would be advisable to first aspirate the growth to ascertain the nature of its contents. It does not make any difference what it is, I propose to remove it. Myxo-sarcoma is about the slowest in development of any of the sarcomatous growths. It is not improbable at all, I think, that this is a dermoid cyst. I think it began in the back of the orbit, and did not show itself until after receipt of the last injury. I do not believe, however, the injury had anything to do with its occurrence.

A LARGE SARCOMA OF LEFT KIDNEY IN A CHILD FIVE YEARS OLD—NEPHRECTOMY—RECOVERY.

DR. W. O. ROBERTS: The first of last December I was called to Shelbyville, Ky., to see a child who will be five years of age the coming April. The history of the case was about as follows: The mother stated that four weeks prior to my visit, she noticed that the child's abdomen was much larger than it should be, and, examining it she discovered a tumor considerably larger than a man's double fist. The child had never complained of any pain or discomfort in anyway. The mother was led to make the examination simply by the prominence of the abdomen.

While running about four days before my visit, the child had fallen flat on his face. He then commenced complaining a great deal about his abdomen and was put to bed. At the time of my visit his temperature was 100° F., and had been so for three days. There was considerable pain and tenderness over the left lumbar region; the child was lying in bed with the legs drawn up. Upon palpation, it was questionable whether there was

fluctuation or simply elasticity of the tumor. I suggested that we aspirate to see whether the growth contained any fluid; this was done at three different points and nothing except a little blood secured. I then made the diagnosis of malignant disease of the left kidney. It was thought by the physician who had seen the case previously that the patient had disease of the spleen. I made my diagnosis chiefly upon the tympanites along the region of the colon.

I did not see the child again until the latter part of December. At that time the tumor had grown considerably; it filled the whole left side of the abdomen down almost to Poupart's ligament, and extended over about two or three inches to the right of the median line. The case was brought to this city for operation, and on January 17th, at the Norton Infirmary, assisted by Dr. Anderson and a number of other gentlemen, I made first a short exploratory incision—a perpendicular one—for the purpose of settling the diagnosis as to the organ involved; it proved to be the kidney as I thought. The spleen was perfectly normal as to size, but was pushed up, of course, by the growth. In this exploratory incision there was an opening made in a little vein on the surface of the tumor which bled very freely, and it was with difficulty the hemorrhage was controlled. I had explained to the father before making the exploratory incision that if the tumor was found of such a character that it could not be removed without too great a risk, the abdomen would be closed. When the bleeding occurred from the punctured vein, I, with the father's consent, went ahead and removed the tumor.

I did the operation suggested by Abbe, whose paper I had a day or two before seen in the *Annals of Surgery*, which consists in opening the abdomen transversely instead of perpendicularly. The short incision made was about two inches, I suppose, to the outer border of the left rectus abdominis muscle. I then carried the other across the abdomen one inch below the ribs back to the lumbar region and across the outer border of the rectus; that brought me down directly upon the growth. We found the descending colon so closely adherent that it was with some difficulty we were enabled to detach it. When we had dissected down to the pedicle of the tumor, the child seemed so nearly dead, that I did not take time to pick out the ureter but tied off the body *en masse*. I found that the tumor grew from the fibrous covering of the kidney, only a portion of the kidney seeming to be involved in the growth; the kidney, however, was removed in its entirety, as I was afraid the other portion might be infiltrated, and which could not be detected at the time. After removal of the

growth the wound was closed by three lines of continued sutures; it had to be done very rapidly owing to the extreme condition of the patient. The peritoneum was brought together first, then the muscular structures, then the skin and fascia. The child was put to bed in almost a moribund condition; however, he rallied and went along to recovery without an untoward symptom. He was discharged from the Infirmary yesterday in good condition, with the wound healed. The tumor which I exhibit for your inspection, was found to weigh immediately after its removal seven and a half pounds.

DISCUSSION.

DR. TURNER ANDERSON: I want to congratulate Dr. Roberts upon his success in this case. I think it was the most formidable surgery that I have ever witnessed. Dr. Roberts kindly permitted me to assist in the operation. The transverse incision extended around almost to the spinous process of the dorsal vertebra so that everything was thoroughly laid open. The adhesions to the descending colon were very extensive; the tumor was also adherent to the peritoneum and had to be dissected off. The whole procedure required the most pains-taking careful surgical work that I have ever witnessed.

DR. W. L. RODMAN: I also wish to congratulate Dr. Roberts upon the successful result in this case. It is the second case of nephrectomy he has had. I assisted him in the first case several years ago. The incision suggested by Abbe is perhaps a very good one; it certainly affords greater access to the kidney than the ordinary incision in front but it strikes me as being questionable whether this incision of Abbe is better than the older operation very much like it; that is, the operation of König, in which he begins posteriorly and cuts anteriorly. The only difference is that Abbe goes through the peritoneum, while König does not. König dissects up a large flap of the muscles and when he comes to the peritoneum it is pushed forward toward the median line, in that way he removes the kidney without doing injury to the peritoneum. The disadvantage in either operation would be the great liability of ventral hernia. While the result in Dr. Robert's case is very gratifying so far as the primary result is concerned, I am very clear in my own mind from statistics on the subject that these operations are done more to show what can be done with the knife than for any real substantial good that comes to the patient. Gross and others have shown very clearly that the mortality of nephrectomies for malignant disease is frightful; in the lumbar operation about thirty per cent., in the abdominal operation about forty-five per cent. One reason why the abdominal is perhaps more

fatal than the lumbar operation is that severe cases are operated upon by the anterior route; you cannot remove as large a tumor by the posterior as by the anterior route. So when you consider that the mortality in these cases is forty-five per cent. further, that no single case of cancer of the kidney has ever passed the three years limit after operation and that very few sarcomas have passed this limit; that many of them die on the table; others dying a few months after the operation; again, the liability of ventral hernia occurring it strikes me as being very questionable whether this operation ought to be done or not.

DR. H. H. GRANT: I agree in the main with what Dr. Rodman has said in reference to operations for the condition under discussion, but in this case it appears that great benefit has been done to the child by the operation, and its life is probably prolonged. If this tumor is really a sarcoma, it is barely possible that the child will entirely recover, although as Dr. Rodman says these operations have not been done very frequently for sarcoma. I believe it is possible in some cases to cure sarcoma of the kidney by complete removal. Several cases are recorded of the prolongation of life and addition of comfort after such steps.

With respect to the post-peritoneal operation for a condition of this kind: Although I have never had an opportunity to see an operation of this character performed it seems to me that in the majority of cases where a tumor of this size is present, it would be almost impossible to remove it without doing injury to remove it without doing injury to the peritoneum, and as at the present day we feel but little hesitancy in invading the peritoneal cavity, it is perhaps just as well to bodily open it as suggested by Abbe, and understand in the beginning just what we were cutting without fear of after results from invading the peritoneum. It seemed to me when I read Abbe's paper that it would not be an unwise thing to make posterior opening through the lumbar region at the time, which would allow thorough drainage and still not disturb the decubitus of the patient. It seems to me this would be an important additional step in the operation, and I believe if I had occasion to do an operation of this kind I would supplement anterior drainage by making drainage in that region.

DR. W. O. ROBERTS: As Dr. Rodman says this is the second case I have operated upon for malignant disease of the kidney, the first one being in 1885. This patient was referred to me by Dr. Anderson, who also rendered valuable assistance in the operation, and in that case there was recurrence of the trouble and the patient died inside of three months.

However there was prompt recovery from the immediate effects of the operation. Regarding the mortality in these cases: Statistics show that about fifty per cent., according to Abbe, die from the immediate effects of the operation. I think Keyes reports a case that lived four years after operation.

In my second case when the operation was undertaken, the father was advised of the opinion of all the gentleman present that it was almost certainly a sarcoma; we told him that if we found it to be a sarcoma and thought it best not to go on with the operation because of that fact, we would simply close the wound; but when the troublesome hemorrhage occurred I saw it would not do to close the wound, hence after consulting with the father, went ahead and removed the growth.

Referring to Dr. Grant's remarks concerning drainage: I will state in this case drainage was made from the posterior angle of the wound, with strips of iodoform gauze put down to the bottom of the wound which drained very satisfactorily. This was removed at the end of forty-eight hours, and another small piece introduced which remained until the second dressing, then no further drainage was made. I think the operation as performed in this case decidedly best where the tumor is large.

The advantage of incision at the outer border of the rectus muscle (Lanenbeck's), over the one in the median line, is that you go through the outer layer of the mesocolon and avoid the vessels lying in the inner layer, and hence avoid the danger of sloughing of the gut. In the operation I performed in the case just reported there were no vessels to be tied.

SEPTIC PNEUMONIA RESULTING IN GANGRENE.

DR. W. L. RODMAN: On December 15, 1893, a young man, Mr. E. H., aged twenty-eight years, while working on the Louisville and Jeffersonville Bridge, fell with a span of the bridge a distance of rather more than one hundred feet. He was not able to say whether he was struck by any timbers or iron in falling. He received a fracture of the fifth, sixth and seventh ribs of the left side. The shock was quite profound but he recovered from it with reasonable promptness. It was noticed at once that one of the ribs must have penetrated the lung as he spat blood copiously with each expectoration, and air could be felt in the cellular tissue over the fracture. This became more marked during the day until the whole side of the chest was quite distended with air, which also passed down the left side of the body; the scrotum was especially dis-

tended being as large as a child's head. He got along very well for three days never having a decided rise in temperature, suffering only at times from short, painful paroxysms of coughing. On the fifth day there was an elevation of temperature, it reaching a point as high as 104° F. That was the beginning of as severe a case of traumatic pneumonia, which was, of course, septic in nature, as I have ever seen. The left lung was solid from apex to base. He had a hard time getting over the pneumonia, but on the fourteenth or fifteenth day he showed symptoms of improvement; the temperature remained very high, hardly ever less than 104° F.; there was no effusion in the pleural cavity. On the sixteenth day his temperature dropped somewhat, and he commenced expectorating a great amount of very offensive matter. It was so extremely offensive that it made all the nurses and patients sick. It was necessary to keep all the windows open, although the weather was quite cold. There was evidently gangrene of the lung, he soon went into a condition of profound sepsis, and I had very little doubt but that he would die. While the temperature was low he had at all times a very copious sweat, the pulse became very frequent, 130 to 140, the skin had that peculiar muddy appearance of sepsis, and he was in a very critical condition. A consultation having been held, it was thought advisable to resect his rib and to see if we could not find the original opening in the lung, and following that as a guide open up the abscess in the gangrenous part of the lung. This was done, I think, about the twentieth day after the accident. The sixth rib was resected, a piece about four inches in length being removed. I used the Rongier forceps, which, by the way, I shall always use hereafter, as I consider it the best instrument for the purpose. Pus was encountered as soon as the rib was cut; the original opening in the lung was easily detected, and a large abscess was found in the gangrenous portion of the lung. The lung was packed with several yards of gauze in strips, and the man's recovery has been very gratifying indeed. He was better the day after the operation and has improved steadily ever since. The abscess was in the upper lobe of the left lung. He spat up the foul stuff for a week after the operation, some of it drained out through the incision, and for the last month he has seemed to be perfectly well. He is able to walk about the Infirmary, is gaining flesh and strength, and altogether his convalescence has been very satisfactory. Pus was discharged from the wound for three or four days; after that time the discharge was only from the superficial part of the wound. It was packed every day for about eight or ten days and then allowed to heal.

DISCUSSION.

DR. TURNER ANDERSON: I was very much interested in Dr. Rodman's report. As we understand pneumonia, I have been under the impression that such a thing as *traumatic pneumonia* was impossible. We may have an abscess or inflammatory process involving the lung, but a veritable *traumatic pneumonia* as we understand pneumonia, is hardly admissible. Of course, the treatment in these cases is plainly indicated as soon as the abscess is detected, as soon as the lung becomes gangrenous—to practice external drainage.

In this connection I wish to claim priority in the matter of practicing external drainage in pneumonia, as I believe I was the first to attempt such a procedure in this part of the country. The case was one of ordinary pneumonia which terminated in gangrene of the lung; it was a severe case in which I aspirated the lung, then enlarged the opening and practiced external drainage between the ribs. The rib was not resected, and I believe that in many of these cases free drainage may be obtained, without removing a portion of the rib, by making an opening in the inter-costal space and inserting a drainage tube.

DR. W. O. ROBERTS: I also wish to congratulate Dr. Rodman; certainly he carried out the proper procedure. The patient was in a very critical condition, and the doctor is deserving of great credit.

DR. T. S. BULLOCK, (Visiting): I have seen with Dr. Anderson two cases similar to the one under discussion, where recovery followed very promptly. In the first case after aspirating, a drainage tube was passed through the intercostal space and thorough drainage established in that way. In the other case he did a resection of the rib and recovery followed promptly. I must say that I never saw such an amount of pus escape from any cavity as was discharged in the last case.

DR. JAS. S. CHENOWETH: I was present when Dr. Rodman operated upon the case referred to. While the patient did spit up a large quantity of very offensive stuff, I was particularly struck with the small amount of pus liberated at the operation. I was rather impressed that there might possibly be a collection of pus which was not reached; however, the patient was very promptly relieved, and it is evident all the pus was removed. I was struck with the small amount of pus and the very grave symptoms.

DR. J. G. CECIL: I want to ask one question in reference to puncture of the lung by a fractured rib. As I understood the reporter, it was evident from the beginning from the symptoms already detailed that the rib had been fractured, and that it had wounded the lung. Would it not have been good surgery therefore to have made an incision in the region of the fracture as soon

as the man recovered from the shock of the accident, and searched for the rib which probably projected into the lung? It occurs to me that this would be good surgery, and might have prevented after trouble such as Dr. Rodman has described.

DR. W. L. RODMAN: I am glad Dr. Cecil has brought up the question of early operation in these cases, and the point he makes is an excellent one. I was tempted to make an opening in this case the second day after the injury. I went over all the literature of the subject very carefully and could find nothing to warrant me in such a course. The books simply state, "In case of depressed ribs, where you are satisfied the lung has been injured, the proper procedure is to take a blunt hook and go down into the rib and aim to pull it up in that way." I did not believe any good would come from such a procedure, so did not attempt it. The next case of the kind I have I shall not hesitate to do as Dr. Cecil suggests; certainly it is the proper procedure in such cases, and there is no danger in removing a piece of the rib, when it is already as in this case a compound fracture, air entering from within.

In regard to the point made by Dr. Anderson: I am perfectly familiar with the fact that the larger majority of medical writers say that we do not have *traumatic pneumonia*. I do not mean to say that in these cases we have the *pneumococcus*, but I do say that this man's lung was solid from apex to base. Another man hurt the same day who is still in the Ward, had the same kind of an injury, although he has not had emphysema and the lung did not become gangrenous, but it was solid from top to bottom—evidently a septic pneumonia. I am thoroughly convinced that any man examining the two patients would have pronounced one lung of each perfectly solid from top to bottom; whether it was pneumonia or not, you can decide for yourselves,—each had the rust-colored sputum, the characteristic respiration, pulse and temperature of pneumonia, and neither at any time had any fluid in the pleural cavity.

DR. W. O. ROBERTS: It is not unusual to have an injury of the lung and fracture of the rib without an abscess; Dr. Chenoweth will remember a case that we exhibited before the class at the University not long ago, where the man had a fracture of the second rib with emphysema. The man recovered without the slightest trouble and without operation.

I do not think it advisable to do this operation in fracture of the rib until there is evidence of suppuration.

DR. W. L. RODMAN: If you knew there was a penetrating wound of the lung, do you not think it would be good surgery to operate at once?

DR. W. O. ROBERTS: Just as soon as there

was evidence of suppuration, then operation should be performed, not before.

Dr. I. N. Bloom read a paper on
URETHRITIS—SIMPLE AND SPECIFIC.

(See page 705.)

DISCUSSION.

DR. H. H. GRANT: I do not speak of these cases from a specialist's standpoint, but it occurs to me that both cases Dr. Bloom describes may be easily explained. In the first case I believe that his patient most certainly had simple urethritis, and it is entirely possible for simple urethritis to have produced this irritation in the woman. I am sure that I have seen a number of cases of urethritis which were simple in the male, certainly cases in which there were no gonococci present; perhaps in many instances there was certain irritation, the result of old strictures producing long-standing trouble, that infected the wife afterward; and while I believe, as Dr. Bloom states, that it is not possible to bring about a cure for gonorrhoea in four or five days, yet I do think it possible for simple urethritis to get well in that length of time to all appearances, and yet afterward may cause vaginitis, urethritis, etc., in the female.

Referring to his second case: A great many cases of gonorrhoea are supposed to be cured while there still remains in the glands, far back in the prostatic portion of the urethra, a quantity of the gonococci which are not in active irritative and aggressive condition, yet they are present and may become dislodged and pass out with the urine or with the semen in sexual intercourse, and in the latter case they are ejected into the female vagina and may be productive of serious trouble. I think there is almost no question about this being the course of infection in the second case reported by Dr. Bloom, and I can see no other rational explanation of the first one. I am sure Dr. Bloom will say without hesitation that a very large number of cases of gonorrhoea are apparently cured, still there may be retained somewhere, either in the epithelial covering of the urethra or in some of the glands or pockets far back, germs able to cause gonorrhoea for a very considerable length of time, even after all manifestations have apparently been cured, and this, too, without there being any particular irritation in the male, or at least any irritation that he is able to define as result of the urethritis. Certain symptoms are nearly always present in individuals who have suffered long from gonorrhoea which remain for a considerable period of time, certainly for a year or more after apparent recovery; the patient feels a sense of discomfort in the prostatic portion of the urethra almost invariably, and sometimes even higher up there is that condition known

as gonocystitis. It is exceedingly common for conditions of this kind to exist long after the original trouble has disappeared.

DR. J. G. CECIL: The cases reported by Dr. Bloom are very interesting to me. Certainly we know it to be a fact that gonorrhoea may exist for a long time in the genital passages of women, in the glands of Bartholini, in the cervix, in the posterior vaginal fornix, and in many places almost inaccessible which generally are overlooked or neglected in any method of treatment that is adopted. The question as to how long gonorrhoea may exist either in the male or female, and how long it may possibly be communicated is one to which I have never been able to give any satisfactory answer, and shall be very glad if Dr. Bloom, in closing, will enlighten us in this particular.

I can hardly agree with Dr. Grant that simple vaginitis will show up in as virulent a form as indicated in the case reported by Dr. Bloom. We may have simple vaginitis occasionally, but I have never seen it involve the urethra to any extent. I have seldom seen it extend to the pelvic region and involve the tubes; in fact I hardly think it is probable that simple vaginitis will ever result in these complications. I am free to say that I can not understand how the first case described by Dr. Bloom could have originated. The second case, especially in its relation to the time when it is advisable for persons to marry after having had gonorrhoea, strikes me as being one of very great moment, because of the prevalence of gonorrhoea among young men, and especially since we know the wonderful number of diseases in the female that result from so-called cured gonorrhoea. I had a case in mind at the time Dr. Bloom was speaking, of a gentleman whose wife had been suffering from some womb trouble, who had, of necessity, to live apart from his wife and had indulged his fancy outside contracting gonorrhoea. He came to me for treatment while his wife was going to another physician for treatment. I persisted with and urged upon him the necessity of complete cure before he again went to stay with his wife, and thought that I had accomplished this, and he thought so, too. Every symptom had disappeared, and he went so far as to make a crucial test by going outside again and trying it on somebody else, and utterly failed in his attempt to communicate the disease. Three or four weeks after all symptoms had subsided he communicated gonorrhoea to his wife.

It is a question that it seems to me ought to be settled in some definite way if possible, because of its importance. Of course no man wants to communicate gonorrhoea to his wife, whether she be newly married or otherwise, and especially since we know that so

many pelvic diseases which require extensive operative procedure to relieve are due to gonorrhœa, it seems to me the question ought to be discussed and settled. I am sorry that I have not something definite to offer, but it seems to me that Dr. Bloom in the cases he reports did follow out every possible precaution that even the most exacting of us could have asked, and yet his cases went wrong. The question will come up to all of us, When can a man marry after he has had gonorrhœa with safety? When should he be allowed to marry?

DR. I. N. BLOOM: I feel very much gratified that the cases I mentioned have been so thoroughly and ably discussed. My object in citing these two cases was to get the different opinions on the subject. I am fully cognizant of the experiments and tests that have been made as to the cause of gonorrhœa, and as yet I am not satisfied and not prepared to state that the germ of Neisser is not the specific germ of gonorrhœa; on the other hand I am also not prepared to state positively that it is the essential germ which produces gonorrhœa.

As regards the first case: Dr. Cecil has answered Dr. Grant exactly as I should have done. I do not believe simple urethritis could possibly produce the symptoms which were seen by one of the physicians present who was called in consultation when peritonitis developed.

In the second case, the man married early in October and had intercourse with his wife during October, November and a part of December before she developed any symptoms of gonorrhœa, and the strangest feature is without a single symptom developing in himself. It is natural to suppose any latent urethritis that might exist would be aggravated by sexual congress the first few weeks of marriage and be at once communicated; I believe that is the usual history of these cases. However in this case nothing in the wife until fully two months after marriage. Some writers claim that a man may be absolutely free from all symptoms for a year, and then communicate gonorrhœa; while such cases may sometimes occur, I believe they are extremely rare. Further, do not some authorities recommend marriage for the cure of so-called gleety discharges in the male, and have not cures resulted in some cases, without any trouble developing subsequently in the female? Yet here is a case where exactly the opposite condition exists—there was absolutely no sign of urethral discharge for a period of several weeks before marriage, all evidence of gonorrhœa having disappeared, yet the wife became infected. We could all cite cases where a discharge was still present, the patient married became well, and the wife was not infected. I do not believe that the gonococci can exist in any part of the urethra for a long time sufficiently active to give a

specific gonorrhœa to anyone, without causing trouble, and specific trouble at that, in the patient himself.

I am satisfied the cases I have reported might be multiplied by many others, and because of the importance of the subject I think they are worthy of discussion and publication. In regard to the specificity of the bacillus of Neisser—I do not think it has been fully established, clinically at least.

DR. BODINE (Visiting): I understood Dr. Bloom to say that his patient had at one time what was regarded as specific urethritis, that the gonococci were present. Is it not possible that some of these gonococci invaded the ejaculatory ducts, during the progress of the urethritis and there remained quietly, producing absolutely no trouble?

By treatment may we not destroy all the gonococci in the urethral tract, but may not some of them during the active stage get into the ejaculatory ducts and remain there? No examination of the urine in such a case, no matter how frequently repeated would disclose their presence, but during the ejaculation of semen in sexual intercourse they might be transmitted to the female. I can understand how this might occur, and simply offer this suggestion as a possible explanation of the infection in the case reported by Dr. Bloom.

DR. I. N. BLOOM: The tendency of the gonococci is to increase and multiply, and I believe all experiments in this direction show that they never lie in a latent quite condition, but are continually developing.

DR. H. H. GRANT: I agree perfectly with what Dr. Bodine has said, and simply rise to answer Dr. Cecil: In the present history of diseases of women, am I not correct in saying that there are certain authorities who maintain that no woman ever marries a man who has had gonorrhœa but suffers in some way from the effect of that gonorrhœa?

There is abundant authority in every surgical journal of the land, and in nearly every surgical book to support the statement I made that gonorrhœa is not by any means cured when the discharge ceases and that in many instances the disease remains latent for a very considerable time. Therefore if it be true, as maintained, that any woman who marries a man who has had gonorrhœa invariably suffers from its effects, it would seem to me that if a man marries a woman within a period of two or three years after he has apparently recovered from an attack of gonorrhœa, it is perfectly possible for the gonococci to produce such effects as Dr. Bloom has described.

The question as to when it is safe for a man to marry after having apparently recovered from an attack of gonorrhœa is one of the greatest importance, and one which in my opinion is far from being satisfactorily settled.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE MEDICAL CHRONICLE

of Manchester, England, for April. Dr. Julius Dreschfield contributes a paper on a

Peculiar Form of Idiopathic Intermittent Fever of Pyemic Character.

The author states that there can be little doubt that the disease is microbic in its origin. He saw in all six cases, they were all men, their ages varying from 28 to 56. All, with two exceptions, had enjoyed good health up to the time of the onset of the disease—one had suffered for some time from the symptoms of alcoholism, and one had had glycosuria for several years before the febrile attack set in. Not one of them had lived in a tropical or malarial climate, nor had any of them ever had malaria, rheumatic arthritis, or any injury. In four out of the six cases the disease was fatal.

The principal symptom noticed in each was a pyrexia, not unlike that seen in intermittent fever—namely a rigor, during which the temperature would raise to 103° F., and sometimes to 107° F. This was followed by the hot stage, and this was succeeded by the stage of sweating; the perspiration, in some of these cases, was so profuse that the clothes of the patient, and even the bed clothes, were soaked through and had to be changed.

The pyrexial attack was followed by a febrile period, during which the temperature was normal or subnormal, and during which time the patient felt quite well. In some of the cases the temperature between the rigors was somewhat above the normal, but yet the patient did not appear to suffer any inconvenience. The rigors occurred in a few cases regularly once a day, generally in the evening, in other cases they occurred at very irregular intervals. Sometimes there were two or three rigors within twenty-four hours, at other times there was no rigor for several days. This irregularity occurred in the same patient.

Abdominal pain was present in three out of the six cases from the first. The pain was not localized nor did it occupy the same position in all; in two it was over the region of the liver, in one over the epigastrium, and in the fourth a mild diffuse pain was felt over the abdomen. In some the appetite remained good throughout, in others there was occasional vomiting, and in one persistent vomiting; constipation was present in all. In none of the cases was there noticed any affection of the lungs or heart. The pulse was steady and slow during the febrile period, and rose quickly to 100 and more during the fever stage. The spleen was found slightly enlarged in all cases. The urine showed little that was abnormal; in only one case did the author detect albumen and hyaline casts in the urine, which was passed about one hour after the sweating stage, and this occurred several times in the same case. The diazo-re-

action was absent in the three cases in which it was tried. An important and noteworthy symptom in three out of the six cases was an enlargement of the liver; but this came on some time after the onset of the disease. Two of these cases terminated fatally (in one of them very slight jaundice appeared a few days before death), and the liver was found to be the seat of suppurative hepatitis. In the third case jaundice came on about six weeks after the onset of the disease, the liver enlarged enormously, but after a time both the liver intumescence and the jaundice gradually disappeared, and the patient made a satisfactory recovery.

Though the prominent symptom in all was the intermittent fever yet the author is certain that the cause was certainly not due to malarial poison, for the patients did not live in a malarial country, and none of them had ever had malaria; the spleen was only slightly enlarged, and increased in size only with the progress of the disease, and quinine, arsenic, and even methylene blue, had no effect whatever on the pyrexia, nor did the attack of pyrexia show any periodicity. In support of the view that the disease is of pyemic origin, the author cites (1) the suppurative hepatitis which was found in two of the fatal cases; and (2) the relation of the disease to some pyemic affection, namely, pyphlebitis and ulcerative endocarditis. (3) The presence of numerous micro-organisms in the liver in one case.

The author, therefore, regards the disease as pyemic and due to a micro-organism which probably enters the system through the digestive tract, and reaches the circulation either through the portal vein or the lymphatics. Either it, or the toxines produced by it, causes the peculiar symptoms, and if arrested in its course, say in the liver, and not destroyed there, it may give rise to suppurative hepatitis, though it is possible that if suppurative hepatitis occurs, this may be due to a second infection. The author is unable to say as to the nature of the micro-organism further than that it appears as numerous clusters of small thick bacilli which appear in close relation with the biliary passages, and in their appearance not unlike the *bacterium coli* commune.

In the treatment of the affection the various antipyretics, quinine, sodium salicylate, antipyrin, antifebrin and phenacetin were used, but none of them appear to have had any good effect. Large doses of quinine, and arsenic, showed no immediate effects in these cases. Methylene blue given in one case appeared to aggravate the symptoms. The recovery of the two cases, the author thinks, was due to the fact that the patients could take a very fair amount of food, and that in this way the patients had sufficient strength to resist the devastating effect of the micro-organisms, whose natural term of life eventually expired.

Thomas Jones, F.R.C.S., discusses
Cancer of the Rectum and its Treatment by
Excision.

In cancer of the rectum, as in cancerous affections generally, it is of the utmost importance that the condition should be recognized before the disease has made much progress. The early symptoms are often insignificant, the patient perhaps merely complains of vague pains in the rectum, or notices that he is becoming more and more constipated. The author impresses the great need for a more regular and systematic examination of the rectum whenever the symptoms point, however indistinctly, to disease situated in that region. Little good can be effected once the affection has involved the tissues outside the wall of the gut. The necessity for a rectal examination in every case of persistent diarrhoea must ever be in the mind of the surgeon.

When the new growth is nodular and very extensive, often almost encircling the gut, the passage of feces will be seriously interfered with, and obstruction may at any time arise. Glandular enlargement may take place late in cancer of the rectum—a fact of considerable importance in regard to the question of operation. The examination, which should be carried out with care and gentleness, is to elicit information on the following points: The character and extent of the disease, and the condition of the rectum as regards mobility upon the other pelvic structures. In this manner is to be settled the question as to whether the disease has travelled beyond the limits of the intestinal wall, and on this hangs the propriety of attempting to remove the disease by excision. It is also possible by digital examination to determine whether the lymphatic glands are enlarged or not; those in the hollow of the sacrum, when enlarged, may be made out through the wall of the rectum.

The author divides the operations for the relief of rectal cancer into two classes: (1) those that aim at the relief of urgent symptoms, and (2) those that have for their object the complete removal of the diseased mass. Among the former, colotomy offers the best prospects. It not only relieves the sense of weight and uneasiness in the part affected, and removes all chance of obstruction, but checks the progress of the disease, and places the patient in a state of comparative comfort. In regard to the question as to whether this operation should be resorted to early or only when the symptoms have become well established, the author states that he is against waiting until the disease has made serious inroads upon the patient's strength. Removal of the cancerous growth by the free use of the scoop or of the fingers may relieve the symptoms of obstruction, and should perhaps be adopted when other means are not available, though this and linear proctotomy have little to recommend them.

The radical cure of rectal cancer can only be effected by free excision from the perineum, but if the operation is adopted indiscriminately it is certain to fall into disfavor. The merits of each case, as it presents itself to us,

must be carefully weighed, and only those cases operated upon in which there is a reasonable prospect of removing the whole of the disease. Before a final decision is arrived at, the rectum must be explored while the patient is under the influence of an anæsthetic, and attention directed to the following points: The extent of the disease and the state of the rectum in regard to mobility in the pelvic space. Regard must also be had to the general condition of the patient with respect to strength and nutrition; his age; as to whether there is any evidence of the disease affecting parts outside and adjacent to the rectum; also, whether there are any symptoms to show secondary deposits in the liver or elsewhere.

The author considers the objection to Kraske's method of operating (by removing the coccyx and left lower part of the sacrum to obtain space for the necessary manipulations and bringing the rectum down to the skin surface) is not founded on any substantial basis. Cripps objected to this on the ground that it favored the production of pockets outside the rectum, in which decomposing fluids might accumulate, but the author has brought down and fixed the entire circumference of the rectum, or a considerable portion of it, and has never witnessed any ill effects from the practice.

In regard to the condition of the patient after the operation and the prospect of a complete cure, the author says that his condition will compare very favorably with that obtained by colotomy, and is infinitely preferable to that in which a patient with advanced cancer finds himself. In most instances the patient recovers sufficiently to enjoy life, and even to resume active work, and it is possible that the disease may not show itself locally, but return in some internal part where its ravages are less dreadful to witness. Besides this, the moral effect of total removal of the disease cannot be overestimated. With regard to the possibility of complete cure, the author quotes the statistics of Cripps: In nine out of twenty-three cases the disease recurred after periods varying from four months to two years, but six remained well after intervals which varied from two to four years.

The author closes his paper with an earnest appeal for early diagnosis. If the disease is allowed to travel outside the limits of the gut the only chance of obtaining relief is by colotomy. To perform excision under these circumstances is to put the patient to needless pain and discomfort.

W. J. Sinclair, M. D., discusses
Ventre-fixation of the Uterus.

The author believes that the bad result in those cases where the uterus is reported as having returned to its original position was due to the operator having used too few stitches to keep up a permanent connection between the uterus and the abdominal parietes. It is of valuable assistance in the operation, he thinks, to seize the fundus uteri exactly in the middle with a suitable small volsella, which can be held by an assistant, and the uterus can thus be drawn by him in the

direction which is most favorable to the completion of any necessary manœuvre. An important point in the operation is the introduction of sponges behind the uterus, immediately on its being drawn forward by the vesicula; these clear the field of operation and prevent injuries of the intestines or any manipulation of them. A drainage tube has been used only when it was necessary to tear down considerable adhesions which might be expected to bleed. The external dressings, when no tube was used, consisted of lint soaked in carbolic acid and glycerine. This was covered with gutta-percha tissue, and occasionally above the tissue is placed a soft flat sponge. The dressings are then kept in position by strapping. The sponge keeps up a gentle elastic pressure, and is not too thick to interfere with the advantages obtained from the use of an ice bag when reaction appears too strong. As it is essential to keep the patient lying on her back at first, the author has invariably introduced a glycerine-padded pessary of the Hoge shape to support the uterus until the adhesions might be assumed to be firm and permanent.

The author reports a number of cases and ends his paper with the following conclusions:

1. The various published series of cases show that the element of danger is almost *ine quantite negligible*. The present writer's series supports this opinion.

2. The operation, efficiently performed, is a permanent cure of the troubles arising from chronic retroflexion of the uterus, complicated with adhesions or inflammatory affections of the tubes and ovaries.

3. When pregnancy occurs after the operation no distress is experienced by the patient, and no unusual phenomena are observable during the pregnancy, parturition, or the puerperal state.

4. Contrary to what might be expected, bladder troubles are quite the exception after the operation, and these discomforts are almost certainly avoidable by care in operating.

5. In a certain proportion of the cases ventral hernia occurs at the site of the cicatrix. How this is to be prevented is one of the problems of the future.

6. After making full allowance for the element of risk and the incidental drawbacks, the operation of ventrofixation is not only justifiable, but is indicated in a certain limited class of cases of retroflexion of the uterus with complications.

THE EDINBURGH MEDICAL JOURNAL

for May contains the conclusion of the paper by John Wyllie, M. D., on the "Disorders of Speech," this number dealing with "Dysarthric and Anarthric Disturbances of Speech due to Lesions Affecting the Motor Speech-tracts" especially the lesions in the second trophic realm. There is also a second instalment of the "Morrison Lectures on Insanity" delivered by John Batty Tuke, M. D.

Francis D. Boyd, M. D., contributes a paper on

The Relative Proportions of the Two Proteids in the Urine in Cases of Albuminuria.

As the result of many observations made by him in cases of acute nephritis, chronic interstitial nephritis, amyloid disease of the kidney, albuminuria of pregnancy and albuminuria of heart disease, the author comes to the following conclusions:

1. That in albuminuria both the proteids of the blood and serum are present as a rule, but there are certain exceptional cases where this does not hold.
2. That we cannot diagnose the form of kidney lesion from the proportions of the two proteids in the urine.
3. That the proportions of serum albumin and globulin may vary widely in albuminous urine.
4. That even in amyloid degeneration, where the patient is very emaciated, the globulin may not be in excess.
5. That in the albuminuria of pregnancy, both serum albumin and globulin are present, the tendency being for the globulin to be in proportionally large amount.
6. That in the albuminuria of heart disease, where there is no chronic kidney disease, the globulin is usually in larger proportion than is commonly found in chronic interstitial nephritis.
7. That in acute nephritis, where there is no haematuria, the serum albumin and globulin are, as a rule, about equal to in proportion; but when there is blood in the urine, the globulin is proportionally large in amount.

J. Ryland Whitaker, M. D., contributes a note on

The Relations of the Axillary Artery.

Quoting from Quain's Anatomy, the author states that the usual description given is as follows:—"First part of the axillary artery—The nerves of the brachial plexus are to the outer side, the external anterior thoracic nerve crosses in front, and the internal and posterior thoracic nerves behind. Second part.—The three cords of the brachial plexus are placed one on the outer side, the second behind, and the third on to the inner side." The author makes quotations from other works on anatomy with all of which he finds fault in that they make no mention of the passing of the inner cord of the brachial plexus behind the artery. According to the author, the relations should be stated as follows:—"The cords of the brachial plexus lie to the outer side of the first part of the axillary artery, and at the junction of the first with the second part, the inner cord passes behind the vessel and gets to its inner side, so that in the second part of the course of the artery the cords of the brachial plexus lie, the outer cord to its outer side, the posterior cord behind, and the inner cord to its inner side."

A. G. Miller, F. R. C. S. E., reports a case of

Acquired Tubercular Disease of Hip and Shoulder Joints.

The patient, whose case is reported at great length in the paper, had been nursemaid for six weeks to an intensely tubercular child. The girl herself had a good family history and had previously been healthy, without

any suspicion of tubercular disease. At the end of the six weeks she developed tubercular disease of the hip and shoulder, and finally of the lungs. Pus from the affected joints was found to contain tubercular bacilli. The girl died a year and nine months after the commencement of the disease. The author accounts for the infection thus: "The girl being a considerable part of the day with the tubercular boy, feeding him, kissing, washing and dressing him and his sores, must have inhaled, and possibly swallowed, a considerable number of bacilli. In some way which we do not perfectly understand, these bacilli passed into the circulation, and were thus potentially in every part of the girl's body. From the cold and damp of the room in which she slept (the season being winter) she acquired an arthritis, probably of a rheumatic character. This arthritis affords an opportunity

for the establishment of a colony of tubercle bacilli which, at first slowly in the shoulder joint, and then more acutely in the hip joint, carry out their usual work of destruction. Later on they establish themselves in the lungs, and produce a fatal issue."

The author acknowledges that it is always very difficult to prove direct infection. In this case he claims that at least the presumption is very strong that the nursemaid acquired her tubercle from the child she had charge of. He publishes the case because he thinks that sufficient care is not always taken to prevent such unfortunate events occurring, and because many are not aware of the risk.

A. Lockhart Gillespie, M. D., presents a review of "Recent Gastric Literature," and Allen Thompson Sloan, M. D., contributes a paper on "The Geographical Distribution of Goitre."

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A. M., M. D.

THERAPEUTICS.

The Subcutaneous Infusion of Common Salt for Acute Anæmia.

Dr. O. Feis (*Therapeutische Monatshefte*, February, 1894) reports three cases of extreme anæmia after abdominal surgical operations, in which the injection of common salt was apparently the means of saving life.

The instruments for subcutaneous infusion are perfectly simple. All that is needed is a tolerably strong canula, a rubber tube, and a funnel.

The infraclavicular region is the best place to make the injection; the skin and all instruments are disinfected in the usual way, the skin raised in folds, and the needle, with the salt solution flowing (to prevent the introduction of air) inserted. From a moderate height the fluid is let flow, the funnel being kept full. If too much collects under the skin, it is stroked away with a gentle massage.

In from ten to fifteen minutes one quart may be infused in this way. The place of the puncture is finally closed with sterilized cotton batting, fastened with sticking-plaster. Drs. Feis and Schwalm have prepared pastilles of chemically pure salt, which physicians may have always at hand.—*Therapeutic Gazette*.

Valerianate of Amyl.

Blanc (*Rev. de Therap. Med.-Chir.*) describes valerianate of amyl, which is the odoriferous principle of the apple,—that is, the essence extracted by distillation together with alcohol. Cider has long been believed by the laity to have some effect on calculous formations, and this seems to be borne out by the fact that valerianate of amyl really has

some solvent action on cholesterol. It is a colorless liquid, of pleasant taste when taken in small quantities, and can be prepared in the laboratory by the action of valerenic acid on amyl alcohol; 1 grain of cholesterol is dissolved by 4½ grains of valerianate at 37°C. and by 3 grains at 40°C. Physiologically the action resembles that of ether, but the special qualities lie in its being a stimulant and sedative to the liver in cases of hepatic colic. It not only immediately subdues the attack, but it prevents recurrence. If the stomach is irritable, it may be necessary first to employ sulphuric ether, following this with two to three capsules of fifteen centigrammes each, given every half-hour until the crisis is past, and continued at longer intervals during the following days. In nephritic colic the drug acts as an antispasmodic and general stimulant only, but no effect is produced on the renal calculi. Muscular rheumatism is frequently relieved, and much benefit is also derived from its use during menstrual uterine contractions. As a sedative, it is of value in hysterical manifestations. Its toxic properties being very slight, as many as five to six capsules can be taken daily, but it is necessary to guard against gastric disturbance.—*British Medical Journal*.

MEDICINE.

Ichthyol in Pruritus.

In the vaginal pruritus of pregnancy, ichthyol has been found very useful. It may be employed in the form of an ointment, made up with lanolin. In some of these cases it has given relief where carbolic acid and cocaine have failed (*Ex.*). In the pruritus, also of diabetes, the drug has proved to be very useful, combined with fifty per cent. of glycerine.

The Aetiology of Headache.

In a recent number of the *Revue Générale de Clinique et de Thérapeutique* Dr. S. Vermel, after a thorough study of the subject, says that he is inclined to attribute all headaches to an oversensitive condition of the sympathetic nerves controlling the peripheral vessels of the cranium and brain, or to an angioneurosis. It may be asked at once, he says, how the same symptoms, from the same cause, can be present in diametrically opposed conditions, such as plethora and anæmia, febrile and apyretic diseases, for example. The idea that the seat of pain is in the cortex has not been substantiated, for when a cortex is irritated there is locally only an hallucination of pain; the real pain is exhibited on some part of the body. Then if the attack of cephalgia is not due to local irritation of the cortex, the seat of the trouble must be in the meninges. It is to dilatation of the vessels of the meninges, causing intracranial pressure, that the pain is due. The vascular dilatation extends to the minute blood vessels in the region of the pituitary body, rupture of which gives rise to the epistaxis from which patients so frequently suffer during an attack of headache. It is clear how this explanation answers for hyperæmic conditions, but how does it account for the same symptoms in anæmia? In anæmia there is a qualitative and not a quantitative change in the blood, the amount of fluid in the vessels remaining the same. In veritable anæmia from excessive depletion of the system, as from hemorrhage or cholera the condition is different; but from the anæmia coincident with neurasthenia, hysteria, chlorosis, and so forth, there is, so far as quantity is concerned, the same condition as in hyperæmia.

In anæmia the vessels are very prone to dilatation, producing an exaggeration of the intracranial pressure, in consequence of over-excitability of the vaso-motor centers allowing of local hyperæmias.

The author definitely states that the seat of pain in headache is always in the dura mater and not in the cortex; that the pain is provoked by the compression of the dura mater produced by increased intracranial pressure; and that this is true of all headaches, whether neuroses, or of toxic or mechanical origin—such as diseases of the brain or of the meninges, constipation, etc., or of reflex origin.—*N. Y. Med. Journal.*

The Treatment of Sprains.

I divide sprains into three degrees, viz., a mild sprain, a severe sprain, and a sprain of a still severer character. The treatment I would advise for a mild sprain would be the use of hot water and massage by means of vaseline. For a more severe degree of sprain I would apply the same treatment, plus Martin's rubber bandage, and urge the patient to walk about; and for the third degree of sprain I would use hot water as before, and a plaster-of-Paris splint, which should not be applied until twenty-four hours after the injury.—*Internat. Jour. of Surg.*

Lubricant for Catheters.

Castor oil is an excellent material for this purpose. It is non-irritating and tenacious. It should always be applied warm, and the bottle containing it should be frequently washed with alcohol. It can be used for silk and rubber catheters alike.—*Dr. J. M. Kitchen.*

Antipyretic Drugs.

Dr. N. S. Davis (*Med. Age*) declares that antipyretic drugs are of value only as nervous sedative! He considers cold the best of all remedies for the reduction of temperature.

SURGERY.**A New Treatment of Mammary Abscess.**

Tweedy (*Medical Press and Circular*) adopts Weber's method of treating mammary abscess.

An early and free incision is made in the breast, radiating from the nipple, and situated at the most dependent part of the abscess.

The finger is then inserted into the wound and the gland structure broken down. This manipulation, it is stated, will have no bad effect on the healthy tissue.

By this process several new cavities will be found, and these, in turn, are to be opened by an incision similar to the first, and the whole thoroughly douched with some antiseptic solution.

The membrane lining the several cavities is to be curretted, and the *debris* removed by a second douching.

Strips of gauze sufficient to fill every interstice of the abscess are to be steeped in a one per cent. solution of carbolic acid, and inserted by means of a long sinus forceps and probe. A large, flat sponge is then placed on the breast and tightly bandaged thereto for twenty-four hours. After this period the dressings are removed, and without further irrigation the cavities are again packed, the sponge and bandage being reapplied as before.

On the third day the process is repeated.

In the fourth dressing the gauze packing is dispensed with and the incisions are drawn together and dressed antiseptically; the sponge and bandage are reapplied.

This last process is repeated every twenty-four hours until healing is complete; this usually takes place about the tenth day. In one of the author's cases the whole process was accomplished without the aid of anesthesia. In only one of his cases was it necessary to make a second incision. The incisions are never longer than is necessary to admit a finger.

Iodoform gauze should be used for packing the wounds.

The author only having treated five cases, cannot say definitely what portion of the above treatment is essential, but he is strongly inclined to the opinion that curetting can be safely dispensed with.

Intubation.

In regard to the comparative merits of intubation and tracheotomy as life-saving measures in the treatment of croup, I do not know of any stronger argument that could be produced in favor of the new procedure than a short quotation from a paper by Dr. L. S. Pilcher, of Brooklyn, during a discussion on this subject before the Kings County Medical Society (*Brooklyn Medical Journal*, August, 1893).

Dr. Pilcher, while advocating the claims of tracheotomy as the greater life-saving operation, makes the following very candid statement: "I believe that it has been my lot to be called upon to do tracheotomy for the relief of croup in a considerable proportion of the cases that have sought surgical relief, and yet during the seventeen years which I have been operating I have been called upon to do the operation but 66 times, notwithstanding the deaths from croup in our city during this period amounted to between 400 and 500 every year. On the other hand, during the past four years Dr. McNaughton has been called upon to intubate 142 times. He has been instrumental in saving 42 lives in four years, I but 22 in seventeen years, notwithstanding 33.33 per cent. of my cases recovered and but 29.5 of his." In other words, Dr. Pilcher was doing tracheotomy on an average of four times in a year, when the deaths from croup during the same period amounted to between 400 and 500.—O. Dwyer, in *N. Y. Med. Journal*, March 10, 1894.

Pruritis Vulvae.

R Potassium bromide..... 2 parts.
Lupulin..... 2 parts.
Hydrargyri subchlor..... 10 parts.
Oliveoil..... 30 parts.

To be used as an external application.

—*Prov. Med. Jour.*

Cough.

In severe paroxysms of coughing from whatever cause, a tablespoonful of glycerine in hot milk or cream will give speedy relief.

Treatment of Hydrocele.

Dr. J. Neumann employs the following method, which he claims is less painful, and less likely to be followed by inflammation than other operations, and effects a cure within a shorter time. After the parts have been cleansed and rendered antiseptic, he punctures the scrotum with an ordinary trocar, withdraws the stillette, and as soon as the fluid flows out, pushes the cannula further up and leaves it *in situ* for two days, holding it in place with a cotton dressing and bandage. After removal of the cannula the swelling and redness of the skin is subdued by cooling lotions, such as led water. The author has tried this procedure in six cases, and was able to obtain obliteration of the sac without the occurrence of inflammation or suppuration.—*Int. Jour. Surgery*.

Gold Chloride in Pill-Form.

Dr. P. Carles advises administering gold chloride in the following elixier:

R Calcined kaolin..... 2 parts.
Calcined sodium sulphate..... 1 part.
Water..... 1 part.

In spite of their hardness these pills are very soluble and retain their constituents unaltered.

Bismuth in Gastric Disease.

Matthes (*Centralbl. f. inn. Med.*) has investigated, both experimentally and clinically, Fleiner's method of treating irritative diseases of the stomach with large doses of bismuth. The results of the treatment were very successful, especially in lessening pain. From experiments on dogs, the author shows that ten to twenty minutes after ingestion the bismuth sinks to the lowest part of the stomach, whereas several hours later it is found spread over and fixed to the stomach wall, being intimately mixed with mucus. Even with a full stomach a large part is also found similarly deposited. Against the action of chemical agents on the stomach wall this deposit of bismuth is most resistant. In men shortly after the ingestion of bismuth, the water used for washing out the stomach returns clear, but if later the stomach contents be expressed, bismuth with mucus is removed. Experimentally bismuth is shown to increase the secretion of mucus. To determine the action of bismuth in cases of erosion, etc., of the stomach, defects were made experimentally in dogs in the stomach mucous membrane and bismuth was then administered. In some experiments nothing particular in regard to the defect could be made out. In two experiments, however, positive results were obtained. In one an adherent crust was found acting as a protection to the defect. Sections taken from both cases showed healing ulcers. In the case of the crust, crystals were found in the granulation tissue, and proved both morphologically and by a color test to be bismuth crystals. No symptoms of bismuth poisoning occurred. Experiments thus show that bismuth adheres to the defect in the stomach wall, and that healing may take place under a crust so formed. This crust is not always found, but its occurrence once shows the possibility of it. Comparison with control animals showed that in those treated with bismuth the defects healed more rapidly. Digestion can go on while the bismuth deposit is present. If an artificial digestion, however, be shaken up with bismuth, pepsin will be carried down by the bismuth and digestion is thus hindered. The author says that both experimentally and clinically Fleiner's method of treatment is practically and theoretically correct with the exception of the question of position (in reference to the site of the ulcer), which he shows to have no influence in regard to the subsequent deposition of the bismuth.—*Provincial Medical Journal*.

PATHOLOGY.

Etiology of Appendicitis.

Hodenpyl (*N. Y. Med. Jour.*) holds that there are two classes of factors in the causation of acute appendicitis: predisposing, which may vary in different cases; and more active factors, of which there seem to be two distinct, but intimately associated elements: (a) bacterial, of which the bacillus coli communis is very probably the most important; and (b) the less well-defined and less understood chemical factors associated with the fecal contents of the intestines. Of the predisposing causes of acute exudative appendicitis, stricture of the appendix is one of the most frequent. This condition though sometimes probably the result of previous inflammatory processes, is, in a large proportion of instances, the result of partial retrograde evolution, the caecal opening, which is much dilated in the infant, gradually contracting until adult age, when it is smaller than the rest of the lumen, and sometimes much constricted. The vermiciform process, like other organs which undergo retrograde evolution, is very prone to become inflamed. Again, the longer the appendix the more liable it becomes to inflammatory changes. Other predisposing causes are adhesions drawing the appendix into abnormal positions, atrophy of the mucous membrane, and concretions. The last-mentioned cause, though formerly regarded as the usual one, does not exist in more than 10 per cent. of the cases of appendicitis. The author, though led at one time by the results of his own investigations to regard the bacillus coli communis as a most important factor in the causation of acute appendicitis, acknowledges that the recent observations of Barbacci have proved the necessity of caution in attributing a too exclusive role to this bacterium. Barbacci has shown that perforative peritonitis is not due to the introduction of the bacillus coli communis alone, but is the result of (1) the escape of faeces and intestinal gases into the peritoneal cavity; (2) the development of other forms of bacteria therein; and of (3) the constant irritation arising from the continual escape of intestinal contents.—*British Medical Journal*.

For Myalgia.

For the relief of myalgia the Practitioner prescribes:

B.	Linimenti chloroformi,	
	Linimenti aconiti	ss f ss.
	Tinct. opii.....	f 5 iii.
	Liniment saponis.....	q. s ad f 5 iv.
M.	Sig.	To be well rubbed into the painful parts.

Nitro-Glycerine in Sciatica.

Dr. Lawrence (*Rivista de Ciencias Medicas de Barcelona*) reports the case of a carpenter of fifty-two years, who suffered for several years with sciatica. In order to alleviate the pain, he had become morphine user, and could not abandon the habit. After trying a multitude of drugs, he gave him a 1.100 solution of nitro-glycerine, one drop three times a day, gradually increasing the dose to five

drops. Relief was almost immediate, and in ten days he could resume his work, completely cured.—*Lancet-Clint.*

ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM APRIL 29, 1894, TO MAY 5, 1894.

Paragraph 2, S. O. No. 86, April 12, 1894, A. G. O., assigning First Lieut. Harlan E. McVay, Assistant Surgeon, to station at Angel Island, California, is revoked. He will be relieved from duty at Fort Huachuca, Arizona, and will report for duty at the Presidio of San Francisco, Cal., relieving First Lieutenant Charles Willcox, Assistant Surgeon, who after being thus relieved will report for duty at Angel Island, California.

First Lieutenant John S. Kulp, Assistant Surgeon, is relieved from duty at Fort Sheridan, Illinois, and ordered to Fort Spokane, Washington, for duty.

First Lieutenant George M. Wells, Assistant Surgeon, will proceed to Fort Bowie, A. T., and report for temporary duty, not later than the 15th instant, during the absence on leave of Captain Jefferson D. Poindexter, Assistant Surgeon.

Leave of absence for two months, to take effect on or about May 1, 1894, with permission to go beyond sea, is granted Major Calvin DeWitt, Surgeon.

Captain C. N. Berkeley Macauley, Assistant Surgeon, is relieved from duty at the U. S. Military Academy, West Point, New York, and ordered to duty at Fort Wingate, N. M., relieving Major Washington Matthews, Surgeon, who on being relieved will repair to Washington, D. C., and report in person to the Surgeon-General for temporary duty in his office.

So much of Paragraph 13, S. O. 79, A. G. O., April 3, 1894, as assigns Major Peter J. A. Cleary, Surgeon, to duty at Fort Wingate, New Mexico, is revoked.

Leave of absence for two months, on surgeon's certificate of disability, to take effect when his services can be spared, with permission to leave the Department of the Colorado, is granted Captain Edward Everts, Assistant Surgeon.

NEWS AND MISCELLANY.

Mutter Lectureship of the College of Physicians of Philadelphia.

The next course of ten lectures, under the bequest of the late Thomas Dent Mutter, M.D., LL.D., "on some point or points connected with Surgical Pathology," will be delivered in the winter of 1896-97 before the College of Physicians of Philadelphia. Compensation, \$600. The appointment is open to the profession at large. Applications, stating subjects of proposed lectures, must be made before July 1st, 1894, to

WILLIAM HUNT, M.D.,
Chairman of the Committee on the Mutter
Museum.

S.E. cor. 13th & Locust Sts., Philada.